

The Encyclopedia of MENTAL HEALTH

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THE ENCYCLOPEDIA OF MENTAL HEALTH

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PHOBIA

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What is a phobia?

A phobia is an obsessive, persistent, unrealistic fear or a dread, and as such refers to a specific state of mind. Moreover, a phobic person has the conscious wish to flee or to avoid an object, a situation, or a perception in the presence of which he feels fear. Defined in this broad manner the term is generally used in medicine without a psychiatric connotation. For instance, a photophobia indicates a tendency to avoid light. More often than not photophobia is caused by some physical condition of the eye that makes the perception of bright light painful. (The word hydrophobia, another term for rabies, is a misnomer: in this disease the feverish patient craves water rather than avoids it.) However, in the main, the term phobia is used in connection with persistent fears of an irrational character. It is, therefore, not proper to call any and every fear a phobia. To be afraid of a fire that rages through the woods near one's house does not stamp one as pyrophobic; nor does one suffer from a dog phobia (cynophobia) because of the wide berth one gives some watchdogs known to be fierce. One speaks of a phobia in a psychiatric context only when the fear of some object or some situation is irrational and persistent. (See *Fear*)

Does a person afflicted with a phobia know that his fear is irrational? Is it entirely irrational?

Most often an adult has the knowledge that his fear is irrational. But with the passage of time, the fear becomes rationalized in various ways. Thus a phobia may acquire the appearance of a normal fear or normal caution. One can then recognize the irrationality by the fact that the fears persist even after the supposed dangers are eliminated. An acrophobe (one who fears heights) will be reluctant to ascend a tower even though he knows that the observation platform is entirely enclosed. A claustrophobic person who fears suffocation in a closed room will feel this way even though the air conditioning works to perfection.

How are anxiety and phobia related?

A phobia follows a state of anxiety. Anxiety, however, becomes a central phenomenon in the phobia. Anxiety is an emotion that serves as the signal of oncoming danger. Anxiety alerts us. Certain endocrine and neurochemical changes that are not too well understood take place in the body when one is anxious, and a variety of bodily sensations may accompany this state of mind. As a matter of fact the feeling of compression of the chest (in Latin, *angustiae*—narrowing) has given origin to the word, anxiety.

Anxiety is an unpleasant feeling that one wishes to erase speedily. Like the "burned child who is shy of the fire," one is tempted to avoid conditions under which anxiety may arise. But as one grows up, one learns to tolerate this unpleasant emotion to some degree. However, in a person who suffers an "anxiety attack," the very signal of alert has become frightening. In him the physical sensations that ordinarily accompany anxiety become immensely magnified to palpitation, dizziness, and profuse perspiration. His thoughts become jumbled, causing him to grow even more agitated. A vicious crescendo ensues, leading at times to utter panic or to paralysis of will and motion.

The phobic person has experienced such attacks and hence he has the strong inclination or even the desperate and absolute need of avoiding conditions under which they may recur.

What causes the anxiety underlying a phobia?

Anxiety is an alert signal of oncoming danger. In morbid anxiety the threat does not stem from an observable, actual, present danger but from one that is only operative unconsciously. Anxiety appears when an impulse toward action is about to overcome the warnings of one's sense of reality or the prohibitions of conscience. One has to keep in mind here that both the impulse and the threat are carry-overs from childhood fantasy or experience. What is feared may be: (1) loss of self-esteem, or (2) genital injury, or (3) abandonment by a beloved or sustaining person. At times, all of these fears may coexist. Anxiety is aroused when the impulse is in the ascendancy in this conflict.

To illustrate: The impulse might be "to take off one's clothes in public." It is highly likely that such an impulse was suppressed in the past by parents or educators, and that it has been repressed by the individual ever since. The desire, being thus cut off from its link to

voluntary action and from conscious thought (for this is what constitutes repression), has then continued an underground life in the realm of the mind. But, on some later occasion, because of some renewed increase in the strength of this exhibitionistic impulse, or because of some weakening of the opposing forces (at a party under the influence of alcohol, for instance), the repression proves insufficient. At this point one experiences the signal of anxiety. Renewed efforts to hold the impulse back may then absorb all available energies, creating a potential state of exhaustion. This is another threat to which one responds with anxiety. When such conflictual, nearly off-balance situations persist for any length of time, a continuous state of anxiety results. (See *Anxiety*)

Such a state has been evaded by the phobia sufferer. He has succeeded in keeping the conflict repressed most of the time. Its surfacing has been reduced to certain occasions. Sigmund Freud, likening these occasions to chemical phenomena, put it this way: A phobia is the precipitate of a generalized state of anxiety. In this sense a phobia represents an economic gain, a saving of mental energy. It is, after all, easier to avoid riding in an airplane, thus accommodating oneself to an acrophobia or a claustrophobia, than to suffer anxiety all the time.

What is the nature of the unconscious conflicts causing a generalized anxiety?

The conflicts can be of all sorts. They are, in the main, unconscious. They might be between feelings of love and hate for the same person at the same time. They might be between feelings of loyalty for one person and such feelings for another. They might be between wishes to dominate and wishes to submit; between assertions of sexual desires and considerations of morality that oppose them. Such conflicts have not found an adequate solution in the anxiety-ridden person. No compromise has allowed all sides to find some fulfillment in the course of social living.

Normally there is an elastic balance between the forces of the id (instinctual desires) and the forces of the ego (comprising senses of reality and identity, feeling for people, and ability to control, etc.) and those of the superego (representing moral and social values). This balance is absent in conflictual states. Instead, the functions of any or all of the three—id, ego, and superego—have had a defective development and their equilibrium is unstable. Under certain circumstances this tenuous balance may be disturbed. This evokes both anxiety and

the wish to avoid it. When such an inevitable and unreasoning pattern is established, one speaks of phobia. (See *The Unconscious*)

Are there ways other than phobia that modify or ward off a general state of anxiety? Do we know why these ways are chosen?

Psychiatrists are just beginning to learn something about the origins of the "choice of neurosis." There are many ways with which our minds can react to anxiety. Some we may call more normal methods than others; some are typical for characterologically sick people; some are neurotic, as in conversion hysteria or in obsessional neurosis. The differences derive mainly from the different defensive maneuvers employed by each individual to ward off or to deal with anxiety and painful experiences in general. The period of life in which a defense was built up and the continuous example plus inborn proclivities are decisive here. (See *Mental Mechanisms; Neuroses*)

How is the phobic circumstance chosen?

How the phobic objects and situations are unconsciously chosen will be illustrated by an example. But one must keep in mind that in true life the richness of unconscious thinking involves great variations and shadings of the paths indicated by it. Stripped to its bare essentials, Freud's classical "Analysis of a Phobia in a Five-Year-Old Boy" will serve as an example.

Proceeding in the reverse direction to that maintained in psychoanalysis, "Little Hans's" unconscious conflicts will be described first, and then will be described the pathways by which his feared object was chosen to act as a magnet for the resurgence of the conflict.

Little Hans at five stood in that period of life in which the Oedipus complex is in full force, i.e., he wished to replace his father in the affections of his mother. His longings for his mother were all the greater because she had just given birth to his little sister. She had to curtail the time of her exclusive attention to him. Under these circumstances the wish mounted inordinately to rid himself of his rivals or to take revenge on them (and, in measure, on his mother, too). But while Hans felt an intense antagonism against his father, he loved him ardently at the same time. He was therefore involved in the following conflicts: (a) he loved and hated his father; (b) he wished to injure his father while his sense of reality and his burgeoning sense of morality warned him against trying to get away with it. The conflict between near-equal forces proved unsolvable to Hans. His constant inner tempta-

tion to take action kept him in a state of anxiety. His parents were impatient at first with his fretfulness and crankiness. But when this subsided and was replaced by a specific statement of an absurd fear, they were alarmed. Hans refused to go out into the street because he was afraid that "a horse would bite him."

The unconscious conflict about the father (and sister and mother) that was underlying Hans's general state of anxiety became transformed into and reduced to the phobia "of being bitten by a horse." There are essentially three roads that lead from the personages and urges of the unconscious conflict to the conscious phobia. The first road is that of actual experience; the second, that of immature, primitive thinking; the third, that of defense by projection.

Hans lived in Vienna at the turn of the century. His apartment was across the street from a freight yard. Many times he had watched the dray horses pull heavy wagons to and from the platform. Probably he had been frightened when one of them fell on the cobblestones and tried wildly to get back to its feet. He reported at least one such incident during his analysis. So much for actual experience as a point of precipitation for an unconscious and fearful conflict. By itself, however, this would not be sufficient to establish a phobia.

To the actual experience must be added elements stemming from immature and primitive thinking. This type of thinking persists in everyone, though it is not ordinarily made use of in waking life. It follows the same rules by which dream images are formed: (1) "displacement," i.e., because of a censoring interference, a shift occurs from one idea to another that has some similarity to it; (2) "condensation," i.e., various images may merge into a composite one; (3) use of symbols, i.e., certain images stand in for basic strivings and objectives common to all humanity.

This type of primitive thinking can be found in Hans's phobia. His unconscious conflict is around the personage of his father. Hans had often played horsey with him. The horse was, therefore, an easily reached image for displacement of the father. Yet the bulky dray horses pulling their laden carts had reminded Hans of his mother too, particularly in the last few months when she was heavy with child. Thus the horse was a displacement figure for the mother as well. Indeed the horse is suitable as a composite image, i.e., a "condensation." Finally, children's play, innumerable fables, and heraldic animals testify to the universality of animal symbols for people.

The third road that Hans's mind traveled was that of projection. By

using this defense he disavowed all aggressive intent and ascribed it to the horse instead. It was not Hans who wished to attack; to the contrary, he saw himself as a potential victim of attack.

The fear of the horse has been substituted for that of the father. Hans's unconscious and unsolvable conflict, which caused him continuous anxiety, particularly in the presence of his father, found a partial, though pathological, solution by being shunted into a specific phobia. He paid the price of a zoophobia in order to maintain relatively peaceful coexistence within the family.

This highly simplified example shows how a phobia becomes the precipitate of a generalized anxiety. In reality, even in one as young as Hans, the unconscious web is of considerably richer weave. The structure of a phobia in an adult is even more complicated because of the greater breadth of his experiences.

What is the course of a phobia?

The course of a phobia is dependent on the fate of the unconscious conflict that underlies it. If there is a shift in the balance of the contending elements, the phobia may be alleviated. So, for instance, the phobia of a very young child may disappear spontaneously when the child makes progress in his toilet-training, i.e., when his ego-function of control has grown in the course of his natural development.

A girl, at the beginning of puberty, may suffer from a street phobia (agyiophobia). She may lose this fear when she has acquired greater comprehension of the new qualities of her sexual urges, and when she has adapted herself to the rules that govern her adolescent society, i.e., when her ego and superego have found a way of dealing with the pubertal increase of her id drives.

A phobia may remain more or less static throughout life except for some modifications produced by encounters with new demands of living. An acrophobe or claustrophobe who never knew that he was afraid of flying may discover his fear only when confronted by the opportunity to travel by plane.

A phobia may grow worse as an ever-widening range of objects and situations stimulates the underlying conflict. Then ever-larger areas of functioning have to be avoided in order to keep free of anxiety. Such a patient may come to renounce any activity that leads him out of the house or even out of bed. Again the cause for such an aggravation of symptoms will have to be looked for in the underlying conflict.

What is the rationale and what are the methods of the treatment of phobias?

Any rational, or even any irrational, treatment of phobia must exert influence on the forces involved in the underlying conflict. Or it must act upon the anxiety aroused by the conflict.

Anxiety is a central phenomenon in phobia. Therefore drug therapy that effectively diminishes anxiety may alleviate a phobic symptom, without removing its causes.

The training of a child, i.e., the strengthening of its ego through benevolent educational measures, may favorably influence the balance of forces in conflict. The reinforcement of positive moral strivings (strengthening of ethical convictions) may help to subdue emerging undesirable instinctual impulses. The psychiatrist who applies any or all of these techniques may be able to help the patient considerably in his effort to gain control over his phobic state.

Psychoanalytic treatment—out of which grew the present understanding of phobia formation—aims to achieve a new, more stable balance between the three mental structures in conflict: (1) it attempts to free the adult qualities of id drives from their bounds; (2) it increases the tension tolerances of the ego, thereby giving skills and comprehension a chance to grow; (3) it deals with the misconceptions of a rigid or defective superego. If successful, the analysis of the specific factors involved in a phobia, together with the maturing of all three psychic structures, should obviate the phobia.

By contrast, irrational methods of treatment maintain or increase the patient's immature state. A magic ritual may permit a temporary release of forbidden impulses, or magic threats or actual punishments may temporarily suppress instinctual temptation and thereby seem to relieve the phobic state. A phobic child, for instance, can in such manner be frightened into going to school.

What about school phobias?

There is a moderate percentage of young children who suffer from an irrational fear of school. It is important to aid them quickly. The longer a child has stayed out, the more difficulty he will have in returning. Furthermore, a child who stays away from school and a child who suffers inordinate anxiety while in school will be unable to learn. This fact will increase his anxiety even more. The cause for the school phobia is not always easily recognized. What is called a school

phobia may cover a whole variety of fears. The child may, for instance, be in fear of competition from all these new "siblings" in the classroom, he may be concerned that something might happen to his mother during his absence from home, or he might fear being abandoned by her. Often the whole family situation needs to be evaluated; frequently the mother of the child needs some psychological help. For some mothers, school separation from the child is extremely hard. The parental reluctance to let go adds itself to the child's fear of new experiences.

Is it necessary to treat every phobia?

Obviously a great many people go through life beset by minor phobias. They neither seek nor need medical help. Help is usually sought at some transitional point. Either the patient has emerged to some degree from a state of mental disturbance and wishes to be rid of the interference that a phobia imposes on living, or he is feeling the threat of the expansion of his phobia into areas vital to his living. The decision as to whether and how a phobia must be treated should be made by a diagnostician who tries to evaluate the underlying conflict.

Is it ever wise to make the patient enter the phobic situation in the course of treatment?

The answer to this question lies with the goal and the method of treatment. The goal might be just to hold the line, i.e., to contain or to respect the phobic area. The treating physician might try to narrow the phobic area through persuasion and encouragement. The patient may cooperate on the basis of trust in the protective power of his physician.

In the course of psychoanalytic treatment, there comes a time when sufficient understanding has developed of the emotional and irrational nature of the elements composing the phobia, so that either spontaneously or with encouragement the patient faces the situation that he has avoided up to this point. If the analysis is to be considered fully successful, this must happen. To enter the phobic situation will also reveal hitherto hidden facets of the unconscious conflict. In addition, the patient who has become more able to tolerate tension and anxiety will be convinced of his newfound strength only if he dares to confront his phobic object or situation: nothing succeeds like success.

What are the present and future directions of research in phobia?

Pharmacological research seeks better drugs to combat anxiety. Psychoanalytic research seeks to deepen our understanding of phobia formation. The problem of the "choice of neurosis" is especially significant in this. Psychoanalytic investigations of parents and children in a family in addition to longitudinal studies of the individual should give us new insights into these matters.

THE PHYSICALLY AND CHRONICALLY ILL, MENTAL HEALTH OF

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Does physical illness affect a person's psychological adjustment?

Physical illness definitely does affect a person's emotions, his outlook, his feelings about himself, and his relations with the people who are important in his life. It brings in its wake problems about work, about money, about the range of social, sexual, and recreational activities, about dependency, and it brings encroachments upon well-established patterns of behavior.

Even brief illnesses cause anxiety because they interrupt ordinary routines of activity and highlight an inescapable kind of human vulnerability. Human resiliency is such, however, that most people quickly return to their accustomed modes of thinking and feeling once they are physically well again. Prolonged or life-threatening illnesses and those requiring major surgery often have a serious impact on psychological adjustment. (See *Anxiety*)

What is a chronic disease?

The Commission on Chronic Illness defines chronic disease as comprising all impairments or deviations from normal that have one or more of the following characteristics: are permanent; leave residual disability; are caused by nonreversible pathological alteration; require special training of the patient for rehabilitation; may be expected to require a long period of supervision, observation, or care.

Some of the more commonly mentioned chronic physical diseases are: arthritis and rheumatism, blindness, cancer, cardiovascular (heart

and blood vessel) diseases, cerebral palsy, diabetes mellitus, epilepsy, multiple sclerosis, poliomyelitis, and tuberculosis.

Cancer is the designation given a group of some two hundred distinct diseases affecting different organs and systems of the body. A feature all cancers have in common is that there is an abnormal growth or proliferation of cells. Since any patient with cancer is likely to present at least several of the characteristics of chronic disease, a good deal of the material discussed here will be drawn from experience with such patients.

Are there many chronically ill people in the United States?

Estimates vary widely, but chronic disease indisputably touches the lives of many millions of Americans. The Commission on Chronic Illness placed the number of those suffering from disabling chronic disease or impairment at twenty-eight million in 1950. Chauncey D. Leake, in his introduction to the book, *Long-Term Illness*, edited by M. G. Wohl, in 1959 stated that there were 5,500,000 people in the United States quite disabled by chronic disease or impairment, and at least four times that many suffering from minor or temporary chronic or crippling conditions.

What kinds of beliefs do chronically ill people have about their illnesses?

As with so many other events in their lives, people wonder about the causes of their illnesses. "Why has this happened to me?" "What did I do to deserve this?" Such self-questioning is very common, and the kinds of answers a person may give himself in reply are of many sorts. The ultimate physical causes of some diseases are unknown, even to the most advanced medical researchers, and the reason why one person may be afflicted with a disease while his neighbor or friend or brother remains untouched by it is often, also, a scientific mystery. But we all want to know the why's and wherefore's of what is happening to us, and, in the absence of established facts—and often even in their presence—we provide ourselves with answers.

Morton Bard and Ruth Dyk of Memorial Hospital for Cancer and Allied Diseases, in their article, "The Psychodynamic Significance of Beliefs Regarding the Cause of Illness," recounted the spontaneous remarks made by a number of patients who had major surgery to the stomach, to the breast, or to the colon and rectum. Some attributed their illness to stress, to overwork, to early deprivations in life, or to worry

over sick parents or children. Others emphasized some way in which they had abused their own health, for example, by eating inferior food, by eating in restaurants, by not having regular bowel movements, or by taking too many laxatives. Still others felt that they had been born with some special susceptibility, that they had been injured by a relative or spouse, or that they were being punished for some wrongdoing.

Bard and Dyk classified most of the beliefs as self-blaming or else as denying guilt with projection of blame onto other persons or onto some supernatural or mechanistic agency. These authors regard the effort to establish some explanation for a threatening illness to be a means of counteracting emotional disorganization, and they feel that the specific beliefs held by any individual stem from earlier experiences in his own life, from the kinds of feelings he has about himself, and from the kinds of expectations he has about relationships with other people. (See *Guilt; Mental Mechanisms*)

How do people react to being sent to a hospital for a series of tests, for treatments, or for surgery?

It is rare to find someone who does not experience any fear or anxiety at the prospect of entering a hospital. Some people are ashamed of these anxious feelings and try to hide or deny them. Others consider it their duty to shield family members from their own fears and dire expectations; they attempt to act unconcerned or to put on a brave front. A minority are openly frightened and pessimistic and demand much reassurance from loved ones.

From his study of psychological reactions to surgery, Irving L. Janis of Yale arrived at certain hypotheses in his book, *Psychological Stress*. He suggested that a moderate level of anticipatory fear before surgery is the most favorable condition for adjusting well to the results of surgery. Those who show an extremely high level of anticipatory fear or anxiety during the presurgical period are more likely to experience intense fear of body damage during the subsequent crisis period. Those who show an unusually low degree of anticipatory fear or anxiety during the period of threat are more likely to react with anger and resentment toward authority figures when faced with the actual results of surgery. (See *Fear*)

What are some of the different attitudes people have toward sickness and surgery?

For some individuals, being physically ill is a devastating experience. Not being able to do everything in their accustomed ways or

in accordance with rigidly set routines makes them feel bewildered and lost, even worthless. Being useful, being fully occupied, even being rushed and pressured, puts the stamp of acceptability on their lives. Having to rely on a nurse or a family member for help may seem shameful and may provoke resentments.

Much depends on the attitudes of one's ethnic or extended family group. In some groups, an ill or incapacitated member will be sympathetically taken care of, for the rest of his life if necessary, and such solicitude will be regarded as his due by the others in his group. A predominant attitude in the United States has been that every person should be striving and self-reliant and independent. If illness interferes with our attempts to fulfill these requirements, there may be an imputation of personal failure.

It is often difficult for relatives and friends, and sometimes for physicians, to understand why one person will unwisely foreshorten his convalescence whereas another person will endlessly prolong his. Usually the reasons can be found in the kind of person the patient is, the pattern of adjustment to life that he has worked out for himself, and his personal system of values.

One woman may feel that the removal of her uterus or her ovaries is an affront that she will never be able to recover from, whereas a woman who has not neurotically overvalued her reproductive system to the relative neglect of all else can take such surgery in stride. A man whose athletic prowess has been a mainstay of his self-esteem will be more deeply affected by the loss of a limb than a man who has built his self-image on a foundation of intellectual pursuits. Similarly, a person for whom "regularity" and avoidance of anything "dirty" have been of abiding importance since childhood can be expected to react, at least temporarily, with rather severe disturbance when surgical removal of rectum or colon requires construction of a colostomy (the formation of an aperture on the abdominal wall) for evacuation of feces. Contrastingly, a male who has enjoyed sexual expression will mourn necessary surgical removal of his genitals, whereas a male who has always harbored guilty feelings about sexuality may exult in their removal.

Are there people who believe they are physically ill, but actually are not?

Yes, there are; and they may be more difficult to treat than those who have an actual disease. Every clinic has had at least a few persons come in and say that they have cancer or some other specific fear-in-

spiriting disease, either before any diagnostic procedures have been carried out or after exhaustive investigations have revealed no cause for alarm. These cancerophobes and others with such fixed ideas are driven by dread, transferred from other anxiety-producing experiences, or by intense guilt feelings, to insist that they have some terrible disease. They are not amenable to simple reassurance since they are determined to suffer, even if it must be from an imaginary illness. Skillful psychotherapy can sometimes alleviate their suffering. (See *Phobia*)

A somewhat similar affliction is known as hypochondriasis, in which there is generalized overconcern or preoccupation with the state of one's health. No specific disease process is necessarily invoked. There may be a succession of ruminations on different diseases as diagnostic work rules out one disease after another, or as effective treatment clears up one actual ailment after another. Not infrequently, a person who has been through a long siege of illness or has undergone major surgery will obtain arrest of, or even freedom from, his disease but will remain hypochondriacal for the rest of his life. Psychotherapy can sometimes be of help in such cases also. (See *Psychosomatic Illness*)

What is psychological invalidism?

It is a situation in which a patient feels a severe impairment of mobility or of his ability to take care of himself or of his ability to work or socialize, but in which no objective evidence or reasons for such impairment can be discovered. This state is different from malingering, in which there is a deliberate effort to simulate illness or injury, usually to avoid work. Psychological invalidism is sometimes thought of in connection with cases where receipt of compensation payments or disability benefits or pensions might play a part in reinforcing hypochondriacal tendencies. But some psychological invalids reap nothing except self-restriction and social contempt. Others, of course, enlist the selfless devotion of a relative or friend or servant.

There are a great number of reactions that might enter into the picture. The stresses of illness or surgery may have been so great or so prolonged as to sap a person's energies and cause severe regression to a dependent state. Or the patient may feel that his illness has done irreparable damage and that he must carefully conserve his remaining strength forever after. Unconscious hostility and guilt are sometimes factors. The most effective measures against psychological invalidism are preventive ones, including thoughtful treatment-planning with the patient, psychological preparation for surgery, and early rehabilitation efforts as soon as convalescence can reasonably be expected.

The opposite of the psychological invalid is the patient who wants to get back to his usual pursuits as soon as possible. He may tend to discount the seriousness of his illness or its treatment. He may even deny that he has ever heard a frightening diagnosis or had a major operation. Though denial is construed as a psychological defense mechanism, such efforts at quick restoration of normal patterns of activity are desirable even if accompanied by some efforts to wipe the slate of psychic trauma clean. Only if denial causes delay in seeking medical help or causes interference with accepting necessary treatment does it require intervention. (See *Stress*)

Can psychiatric treatment or psychological counseling be helpful to the chronically ill?

It is the considered opinion of many specialists who do consultative work with the physically ill that a person's own physician who is treating the illness should remain in charge of the patient's total care. He can provide continuity and reassurance over the long run. Especially is this so with illnesses such as diabetes, which may require attention to diet and insulin intake each and every day for decades of a person's life, or arthritis, which may require attention to methods of pain control over the course of many years.

But there are situations in which special regard for psychological factors is essential, or at least very desirable. Depression is not an inevitable concomitant of physical illness. If, for example, a depressed state does not lift, or worsens, many months after surgery, psychotherapy or use of carefully chosen antidepressant medication under the direction of a psychiatrist may prove beneficial. Sometimes an ailing person who previously was merely crotchety, under the additional stress of surgery or prolonged illness, becomes progressively more wary of people and more seclusive and then becomes outrightly suspicious and accusatory or delusional. Again, these are not ordinary reactions to being physically ill, and they may require skilled intervention. Psychiatrists, clinical psychologists, and psychiatric social workers are appearing on the regular or consultative staffs of more and more hospitals and clinics in recent years. (See *Psychotherapy; Depressions*)

Do thoughts of death commonly accompany chronic illness?

As would be expected, thoughts of death are common. Ultimate death is one of the skeins of reality each of us works throughout life. Illness tests the fabric of our lives. To change the metaphor, illness foreshortens our perspective of life. That a patient entering a hospital

or a patient attempting to assimilate a newly learned diagnosis should think of the possibility of death or should experience an intensification or reawakening of religious feelings need alarm no one. If thoughts of death become obsessive and unrelentingly oppressive or take on suicidal coloration, psychiatric advice is to be sought without delay. (See *Death; Suicide*)

What credence is to be placed in formulations implying that certain physical illnesses, such as tuberculosis, arthritis, stomach ulcers, and certain cancers are caused by neurotic patterns of behavior or by psychological stress or traumata?

In the view of this writer, very little. Diseases that constitute, or have constituted, mysteries to medical science have been dealt with in this fashion. As the physiological bases of a physical illness become better known, less such speculation about its possible psychological causation is indulged in. Much of the research on the psychogenicity of cancer, for example, has been poorly designed, faultily executed, and illogically reported.

At the present stage of our understanding of these matters it is much more important to deal realistically and expeditiously with the observable psychological *effects* of physical illness. Stresses such as pain, restrictive diets and regimens, hospitalization, surgery, organ loss, changed body form and functioning, and progressive crippling are all severe challenges to a person's integrated adaptational patterns. The stronger and healthier these patterns are before illness strikes, and the greater the attention given to protecting and reinforcing them during the course of illness, the less disrupting to an established way of life is an illness likely to be.

THE PHYSICALLY HANDICAPPED AND MENTAL HEALTH

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Who are the physically handicapped?

The term "physical handicap" refers to a long-term impairment of bodily function or other physical defect that places the individual at a disadvantage in one or more important spheres of normal life activity such as getting an education, earning a living, or establishing satisfactory social relationships. For example, a child who does not hear well may have difficulty in following the class recitation; a man who cannot see is not eligible for certain kinds of employment; a young woman with a facial deformity may find her social life severely limited. Thus, the physically handicapped are those who have some physical condition—disability or defect—that places them at a disadvantage in our culture.

The disadvantage associated with a particular physical condition stems, in part, from the limitations of specific abilities imposed directly by the condition itself. For example, a college student whose legs are paralyzed may be unable to attend a class that meets on the second floor of a building that has no elevator. Similarly, a sightless person cannot operate his own automobile but must depend upon public transportation or upon special assistance. Deafness may make interpersonal communication a major problem.

But beyond such direct limitations of specific abilities, an even more important source of the disadvantage associated with physical disability or defect lies in the strong negative social significance that physical disabilities have in our culture. Such conditions as paralysis, blindness, deafness, and facial deformity are generally regarded as tragic. Persons who have these or other disabilities or defects are often regarded by the nondisabled as unfortunate and are frequently the objects of pity and of social rejection. The paralyzed college student may be refused membership in the fraternity of his choice because the members do not want

to be identified with "a cripple." A blind man may be refused employment even in a position not requiring vision because he might "make the other employees uncomfortable." Even though a young lady may be unusually well qualified for work as a receptionist in all other respects, her facial deformity may be so disturbing to other persons that she is not seriously considered for employment of this kind.

Thus, the physical impairment influences the behavior and adjustment of the person in these two ways: (1) by means of the specific limitations of function imposed directly by the impairment itself, and (2) by means of the negative social significance of physical deviation in our culture. Both kinds of influence are important in attempting to improve our understanding of the problems faced by the physically handicapped.

How many physically handicapped individuals are there in the United States today?

Careful measurements of the frequency of disabling physical conditions have not been carried out. Recently, however, some important results have become available from the continuing United States National Health Survey that was begun in 1957, to secure current information on health conditions such as disease, injury, and impairment for the nation as a whole. Through nationwide household interview methods, this survey reported that, in the year 1957-58, more than 40 per cent of the population had one or more "chronic conditions," i.e., long-term disease or impairment including mental conditions. This is equivalent to an estimated 70 million persons in our civilian, noninstitutional population. For 13.5 million of these, the conditions were so severe that the persons were described, by the informant, as being limited in either the amount or kind of activity they were able to undertake, and another 3.5 million persons were unable to carry on their major activity, i.e., employment, housework, schoolwork.

Thus, for the noninstitutional population as a whole, it is estimated that about 10 per cent had some degree of long-term limitation of activity due to chronic illness or impairment. Moreover, an estimated one million persons were confined by their physical conditions to their places of residence, and a total of 3.5 million were reported either to be unable to get around by themselves or to have difficulty in getting around without assistance.

Although accurate information about the prevalence of different types of disability is not available, the results that are now coming in

from the United States National Health Survey are useful approximations. Estimates of the national prevalence of selected impairments and chronic conditions, based on this survey as of June 1958, are as follows:

| IMPAIRMENT OR CHRONIC CONDITION | ESTIMATED NUMBER OF CASES |
|---|------------------------------|
| Orthopedic (except paralysis or absence of major extremity) | 9,894,000 |
| Hearing loss (short of complete deafness) | 5,714,000 |
| Heart condition | 5,000,000 |
| Visual defect (short of complete blindness) | 2,064,000 |
| Diabetes | 1,500,000 |
| Blindness (no useful vision) | 960,000 |
| Paralysis | 827,000 |
| Absence of major extremity | 282,000 |
| Facial disfigurement | 217,000 |
| Cerebral palsy | 112,000 |
| Deafness (no useful hearing) | 109,000 |

Although these findings constitute the most dependable information yet available on the frequency of long-term disability, they must be regarded, at best, as estimates. They need to be checked against the findings of large-scale, systematic studies that utilize careful physical examinations and medical diagnoses rather than informants' reports as a basis for identification of disability.

Additional evidence on the number of physically handicapped persons is found in the estimates of the Office of Vocational Rehabilitation, United States Department of Health, Education, and Welfare. This information suggests that there are some 2,150,000 persons of working age who have a chronic disability that is a handicap to employment, but who probably could become employable with the aid of an adequate program of rehabilitation. This overall figure remains fairly constant because the number of new additions to the group each year—about 270,000—is roughly equaled by the number who drop out as a result of rehabilitation, aging, death, or other reasons.

The findings presented here, and supporting evidence from other sources, demonstrate clearly that physical handicap constitutes a social, economic, and human problem of substantial proportions. Disability affects not only the person himself, but also his family and friends, often in important ways. It is perhaps no exaggeration to say that half the people in the United States are affected rather directly by physical handicap—their own or that of someone close to them. Somewhat less direct, but no less real, is the fact that social and economic implications of disability leave none of us exempt from its far-reaching influence.

Is physical handicap more common in males or in females? In lower-income classes or in upper-income classes? In older persons or in younger persons?

The National Health Survey showed no appreciable difference between males and females in the prevalence of limiting physical conditions generally, although there appear to be sex differences among some types of disability, e.g., speech defects and conditions resulting from injury are more common among men than among women.

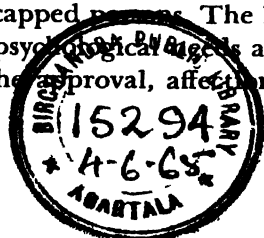
The prevalence of chronic limitation due to physical condition is inversely related to the income level of the family. As income level rises from \$2,000 per year to \$7,000 per year or more, the per cent of persons having some degree of chronic limitation on their activities drops from 21 to 7. However, these data cannot tell us whether the low income is responsible for the chronic disability or whether the chronic disability is responsible for the low income.

The evidence is clear, showing that the incidence of all types of physical handicaps rises steadily with increasing age. Chronic limitation on activity increases from 1 or 2 per cent of all persons under fifteen years of age, to 55 per cent among those aged seventy-five or more.

Do the physically handicapped differ from the nonhandicapped in personality characteristics? Is there a special "psychology of the handicapped"?

At one time it was quite commonly assumed that persons with physical handicaps were different from other persons in basic personality traits. Many writers, and even persons engaged in professional work with the handicapped, have expressed the opinion that the disabled are different psychologically from nondisabled persons.

In recent years, however, as more and better scientific evidence has accumulated, this assumption has become untenable. The bulk of the evidence now available indicates quite clearly that the physically handicapped, as a group, are not unique or different psychologically. Among the handicapped one finds happy, effective, well-adjusted persons, persons with difficulties and personality peculiarities, and persons who are really quite sick psychologically in about the same proportion as found in the population generally. The handicapped are not a homogeneous group psychologically, but are characterized by individual differences just as are nonhandicapped persons. The handicapped have exactly the same kinds of basic psychological needs as the nonhandicapped—needs for self-esteem, for the approval, affection, and respect of others (par-



ticularly those closest to them), for security, and for a sense of purpose and direction in life. The same psychological principles of learning, motivation, perception, personality development, and social adjustment apply to all persons, whether handicapped or not. There is no special "psychology of the handicapped."

But this does not mean that disability has no effect upon behavior and personality. Careful studies of individuals repeatedly have shown that physical characteristics can play a very prominent role in determining the person's social behavior and personality adjustment. But disability per se does not have a simple or direct effect upon behavior and personality. Rather the effect is mediated by what the disability means to the person. The disability's significance to the person is determined, in turn, by a complex set of factors, including the attitudes of the person himself and those of others, particularly those of his family, the age at which the impairment occurred, the person's pre-disability personality, and whether employment or other meaningful activity is still open to him.

This problem is carefully considered in an important new book in this field, *Physical Disability—A Psychological Approach*, by B. A. Wright.

Are the severely disabled more seriously maladjusted than those with mild or moderate degrees of disability?

No. On the basis of evidence currently available, it seems clear that there is no simple relation between severity of impairment and extent of personality disorganization. The deaf, the blind, and the severely crippled do not in general display more serious maladjustment than do the hard of hearing, the partially seeing, and the moderately crippled. This lack of relation between degree of impairment and extent of personality disturbance is one of the most consistent findings in research on the psychological impact of physical disability. It has been demonstrated with several different types of disability, including both auditory and visual impairment, facial disfigurement, and cerebral palsy. The explanation for these surprising results is still obscure, but some writers believe that the mildly disabled are more insecure due to lack of clarity of their status. Sometimes they are regarded as handicapped and at other times as essentially "normal." The severely disabled, on the other hand, are in a much less ambiguous situation. Even though more restricted, their status at least is clear—they know and

others know that they are disabled. But here again, the need is for more and better research to clarify these relationships.

The available research evidence on this and other aspects of the psychology of physical disability is critically reviewed by Roger G. Barker, B. A. Wright, Lee Meyerson, and M. R. Gonick, in their classical study, *Adjustment to Physical Handicap and Illness: A Survey of the Social Psychology of Physique and Disability*, Bulletin #55, Social Science Research Council, 1953, revised edition.

Are there special or unique personality constellations or patterns of adjustment associated with different kinds of physical disability?

No. This is one of the most dramatic findings of modern research on the psychology of disability. For example, the old stereotypes about the hard of hearing being paranoid, the tubercular being euphoric and sexually hyperactive, and that there is an "epileptic personality," have not been supported by the available research data. Attempts to identify particular kinds of personality organization or patterns of adjustment peculiar to specific categories of physical impairment have been singularly unsuccessful. Just as there is no special "psychology of the handicapped," so also there does not appear to be any special "psychology of the crippled," or "the blind," "the deaf," "the epileptic," "the tubercular," or any other type of disability. This again suggests that there is no direct link between physical disability and behavior or personality. To understand the sometimes truly profound effects of disability on behavior and personality, one must go beyond its label and find out about its unique significance to the individual.

The interested reader will find the previously cited works by Barker and B. A. Wright helpful in exploring this question more fully. There is also an excellent collection of short papers by noted authorities on several types of disability, edited by James F. Garrett, *Psychological Aspects of Physical Disability*, a publication of the Office of Vocational Rehabilitation, United States Department of Health, Education, and Welfare.

What are the main problems that confront the physically handicapped?

First, persons with impaired physique face limitations of freedom. A number of activities are closed to them or are accessible only in a modified form, or by means of special arrangements. A crippled, deaf, or blind child may not be able to attend the neighborhood public school

with his brothers and sisters. An accident may require that a logger give up his life in the woods—the life he loves and the only life he knows. A paraplegic may be unable to attend college unless he can arrange for a relative or a companion to live with him. Such limitations of freedom are very real facts of life and must be acknowledged both by the person with the impairment and by those who work with him.

Lee Meyerson, in "Physical Disability as a Social Psychological Problem," found in a special issue of *The Journal of Social Issues* (Fall, 1948), reports that ". . . difficulty in finding employment is so great that each year we must conduct a 'National Employ the Handicapped Week' so that even relatively small numbers of disabled persons may enjoy the right to work. Social distance in more personal areas is equally great. In one study of college students, 65 per cent said they would not marry, and 50 per cent would not even date a person of the opposite sex who had an amputated leg. In the same group, 85 per cent would not marry and 72 per cent would not date a deaf person."

A second major problem of the physically handicapped is this: the activities that are open to them and in which they must spend much of their time and energy are frequently activities that carry low social value in the culture and have little attractiveness to the handicapped person. A child with cerebral palsy may spend much of his time in accomplishing the simple, routine activities of everyday life such as dressing, eating, and caring for other personal needs. His nonhandicapped peers can use part of this time for other more highly valued activities. The partially paralyzed college student may have to allow much more time for transporting himself about the campus, time that his peers can use in more interesting and valued activities. Handicapped workers often find that the only employment available to them is in menial, unattractive jobs with low pay, little satisfaction, and few opportunities for advancement. Even so, such employment is eagerly sought after by many handicapped persons because it is preferable to the hopelessness and social isolation of complete dependency, which may be their only alternative.

A third major problem of the handicapped is the uncertainty they often feel, because they are unsure whether they will be able to manage in a given physical situation, or because they are unsure how they will be treated in a social situation.

Physical insecurity for the disabled arises from the fact that, because of their impaired physique, they may not be able to cope with aspects of the environment that are designed for the use of persons with

"normal" physique. For example, a few steps with short rise, wide treads, and a handrail, may be manageable for a person using crutches; nevertheless, he may feel uncertain of his ability to enter the building to which they lead until he actually tries the steps. Even then, special conditions such as unusually large crowds of people, rain, or snow are contingencies that add to the person's uncertainty as to whether he will be able to manage without embarrassment. Another example: A hard-of-hearing person who depends heavily upon his ability to read lips, frequently faces uncertainty. The illumination in the room may be insufficient to enable him to see clearly. The person whom he wishes to understand may talk too fast, look the other way, or may be sitting in a rocking chair.

This point is made rather dramatically by R. G. Barker and B. A. Wright in the collection of papers edited by Garrett:

"The cultural world of houses, jobs, automobiles, and cities is devised with the requirements of a broad group of relatively 'normal' people in view. For this group, society goes far to structure and define the physical conditions of life. Only if this is done, are people free to make plans with the expectation of carrying them out. When a physically normal person starts to work he generally knows what is possible and what is impossible for him in the way of perceptions, physical locomotions, and manipulations, and he knows that within the limits of what is possible he can usually accomplish the day's tasks. He knows that the steps of the bus will be of convenient height, that the seats will fit him, that the walk from the bus stop will not exhaust him, that the controls of the elevator will be within reach, and that his employer's instructions will be understandable. He knows, in short, that the world of cars, towns, and offices, which society has constructed, is made for his convenience. One can easily imagine the changed outlook of a physically normal person as he started to work if he knew that the steps of the bus might be five feet high, that the seats might be without backs, that his office might turn out to be ten miles from the bus station, that the controls of the elevator might be ten feet above the floor, and that he might be unable to hear his employer.

"This is, in some degree, the position of the physically handicapped person in a 'normal' world. In many situations he is faced with a much greater uncertainty than are normal persons as to whether he will be able to carry out the locomotions, manipulations, and perceptions necessary to achieve his purposes."

Social uncertainty arises from the fact that persons with physical

handicaps are the objects of inconsistent and often conflicting attitudes. Research evidence clearly supports the conclusion that public, verbalized attitudes toward the disabled generally are not unfavorable, but that deeper-lying and unconscious attitudes are often hostile. Thus, the handicapped person cannot predict whether he will be accepted or rejected, whether he will be recognized as a person with skills and abilities like anyone else or seen as a helpless, ineffective, tagalong. At one moment someone may be gushing over him and his ability to do such a simple thing as lighting his own cigarette. At the next moment he may be ignored by the very same person and completely left out of a group discussion because he is not thought of as an effective contributor.

Most of the troubles of the physically handicapped derive from these three problems—limitations of freedom, low social value of accessible activities, and great uncertainty. But these problems have been insufficiently studied and their effects upon behavior and personality are only poorly understood.

What can be done to reduce these problems?

Several kinds of effort may be directed toward reducing the limitations of freedom, the social devaluation, and the uncertainty experienced by the handicapped person. Programs of physical restoration and social and vocational rehabilitation are now developing rapidly. Recent developments in research on prosthetic devices and other mechanical and electronic aids are giving substance to the long-held hope for important reductions in the specific functional limitations of particular disabilities. The programs of research and demonstration of the United States Office of Vocational Rehabilitation and of private foundations are discovering new and more effective ways of helping handicapped persons find more satisfying lives.

It is clear that the problems of impairment or physical defect must be handled in large measure by the disabled person himself. After the best of rehabilitative procedures, the person must come to terms with himself and learn to accept himself for what he is. This requires that he recognize his limitations realistically and keep the physical impairment in perspective as only one of his characteristics, perhaps not even a very important one. If he can learn to focus upon his abilities—upon what he can do—rather than being preoccupied with the disability, his chances of good adjustment and a satisfying life are improved.

But it should be equally clear that, because of the very nature of

physical handicap, the problems of the disabled can be greatly reduced by improvements in public and private attitudes toward the disabled and through concerted programs of social action toward equalizing opportunities for full participation by the disabled. The ground swell of public interest in doing something for the disabled, which has swept this country and much of the world in the past decade or so, has made important inroads on the prejudices and negative stereotypes about the disabled that were so prevalent at the turn of the century. But only a start has been made. The most critical need in the whole field of the mental health of the physically handicapped is for more and better research on the sociopsychological situations of persons with disabilities and on how these situations can be modified to facilitate the adjustment process within the individual.

PLAY, RECREATION, AND MENTAL HEALTH

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I. ADULTS

Can the terms "play" and "recreation" be clearly defined?

Although definitions of "play" and "recreation" are found in every dictionary, deeper consideration of the terms uncovers a surprising fact: no one definition covers these commonplace activities. The Second Conference on Group Processes in 1955, attended by authorities from several disciplines, failed to formulate a satisfactory definition of play. Nor is it possible to find a unitary explanation of play. As Robert Waelder stated, play is a phenomenon that may have various meanings, may perform various functions, and cannot be explained by a single interpretation.

Certain cultural backgrounds lend themselves to derogatory attitudes toward play—as if it has no value, is childlike, or merely kills time. In marked contrast, Plato believed that play arises from an instinctual need and is a vital function. We do know that beneath the surface, play is more than just pleasant. It contains a serious element, and vital positive changes in the human being can result from play.

Recreation is also a well-recognized human activity whose function is to recreate the individual, thus resulting in an inner state of refreshment. The state of well-being and the recreation are its essential features. This state of mental health is believed by some to occur as the result of the revival and gratification of a fantasy of which the individual is not aware, i.e., it is mostly an unconscious fantasy. It is for this reason that there may be refreshment even in one's work. The essence of work and play is not inherent in the activity itself but in the unconscious meaning of the activity to the individual performing it. Recreation includes many of the qualities of play and may at times be a repetition, extension, or elaboration of play. But many activities, even work, not ordinarily associated with play, may be recreational.

Does too much work and not enough play cause mental illness?

No. Mental illness is not caused by overwork. Although work may be a burden, it also furnishes the individual with vital gratifications. Sigmund Freud said, "The daily work of earning a livelihood affords particular satisfaction when it has been selected by free choice. . . ." This is true because the free choice was motivated by a wish, and the gratification of the wish through work makes work a pleasure. The more varied and creative the work, the more opportunities it affords for gratifying conscious desires and unconscious fantasies, and for contributing to the individual's mental health.

With some patients it is clear that work itself serves as treatment. If forced to stop working, an illness may erupt.

However, when work furnishes no fulfillment of underlying wishes, it becomes restrictive, and the need for recreating becomes imperative. Sufficient appropriate recreation or play is then needed to relieve the accumulated excessive inner tensions. Appropriate play would be that which gratifies underlying wishes not being gratified at work.

Do holidays and vacations contribute to mental health?

Yes. They serve the vital function of temporary surcease from the pains and hardships of life. Holidays, vacations, recreational periods, and accompanying activities facilitate the revival of gratifying fantasies. Daily rules are to some degree put aside. A festive feeling usually accompanies this new, though temporary, freedom. A sense of well-being that allows the individual to return refreshed and revitalized to his daily work routine may be generated. A good vacation is an emotional growth experience resulting in a new supply of energy for application to work. This is the reason for its frequent prescription by physicians for overwrought patients. However, care must be taken not to delay vital treatment of serious mental illness by prolonged vacations. The old standby prescriptions for so many so-called nervous breakdowns, "to take a rest," should not be dispensed indiscriminately. Having nothing to do can be not only a dulling experience, but it can even be an emotionally disturbing one.

Are holidays and vacations sometimes harmful to mental health?

Yes. It is quite common to observe symptomology associated with holidays and vacations. For many individuals, leisure time is a dangerous time. It is the time during which some persons fall victim to accidents of all sorts. Hostilities between married couples are seen to break

out into the open. For many children, summer months can be a time of great boredom, unhappiness, or excessive daydreaming. Psychiatrists have described clinical entities erupting during leisure time. Other clinicians have described emotional conflicts finding expression during holidays such as Christmas and Thanksgiving.

Does participation in athletic activities contribute to mental health?

Yes. This apparently is one of the functions of active participation in sports that contributes to their popularity. Helene Deutsch emphasized this method of mastering inner anxiety in her observations that an individual may project an inner danger onto the outside world and through maintenance of certain conditions create a pleasurable game instead of a phobic reaction. She said, "The sport situation provides the most ideal conditions for the release from fear, namely, expectant readiness, contempt of the danger that threatens, a trial of the subject's own powers, and rational attack and defense." It is commonplace to hear busy professional men and businessmen emphasize the value of a round of golf to their mental well-being.

Is being a spectator also recreational?

Yes, of course, it is; otherwise spectator events would not be as popular as they are. However, being merely a spectator excludes one of the chief benefits of recreation. Passively observing others perform does not allow for the stimulation and development that accrue to an individual through active participation. The continuous spectator's position carries the threat of a peculiar kind of malady that has sometimes been called "spectatoritis." It is not uncommon to observe men, whose self-identities are intimately enmeshed with their local or college athletic teams, become depressed or elated in relation to the victory or loss experienced by the team, rather than in relation to their own performances and fortunes.

Can recreation be misused?

Yes. Recreational activities can be executed compulsively instead of being savored in a leisurely manner. For example, this is most often seen in male adults on so-called vacations. They play golf or go sight-seeing in a frenzy of activity. They appear driven to prove how capable they are in playing, instead of being able to relax and enjoy whatever they are doing—even if it is doing nothing.

In children, compulsive play and recreation can be seen when a child repeats the same activity, like going down a slide or throwing a ball against a wall, over and over and over again without ever tiring of it. The child seems driven from within, and is controlled by the activity rather than rewarded by it. The play becomes repetitive and monotonous.

Fear of relaxation, even to that severe degree experienced by those patients who are afraid to fall asleep, is a clinical entity observed by psychiatrists. People who live compulsively may play compulsively, resulting in the loss of the very essence of the value of playful activities. Some people are able to allow themselves recreational activities or vacations only after they have been told to do so by a doctor. This may be the result of a childhood culture whose moral values taught them that that which is pleasurable is bad and that which is painful is good. A. R. Martin has observed the tendency of our culture to work and to play compulsively, rather than leisurely. He calls such people victims of a compulsive, authoritative regime who, in complex ways, distort and abuse recreation by using it for compulsive motives rather than for healthy motives.

What agencies provide recreational facilities?

Public-spirited religious and community groups in the last several decades have recognized the need for recreation in the lives of both the old and the young. Institutions or community centers have been established to provide facilities for wholesome recreational activities such as sports, dances, social parties, lectures, and dramatics. These are used constructively by trained supervisory personnel, who, in working with the younger age-groups, place additional emphasis on character building. Prevention of juvenile delinquency is an important function with some of these agencies. For older persons, the activities stress maintenance of social relationships. These agencies are excellent examples of mental health promotion and mental illness prevention in contradistinction to treatment of mental illness.

What is recreational therapy?

The promotion of mental health through use of recreational activities is an outgrowth of psychiatric utilization of recreation as therapy in a mental hospital setting. Most psychiatrists believe in the therapeutic value of a well-planned recreational and occupational therapy program. This involves professionally organized and prescribed activities

selected for the special needs of the individual patient. The aim is to direct troublesome feelings into socially approved outlets. Also, the successful redirection and mastery of these feelings contribute to regaining a sense of well-being and confidence.

Certain types of recreation have been found to be useful adjuncts to preventive medicine as well as to treatment. Music has been recognized for its therapeutic values and has been utilized in psychiatric hospitals. It has been used both as a listening activity and for active participation in response to the rhythm. Emotional release through dancing has been widely recognized. Art work such as painting and sculpturing have proved useful both as emotional release and creative refreshment. Free art expression has been used for both diagnostic and therapeutic purposes as well as for an objective means of following the progress of therapy. Carving and modeling are time-proven occupational therapy activities. The frequent use of drama as a recreational activity in mental hospitals led naturally into the current use of psychodrama, which is a type of group psychotherapy so constructed as to help people develop insight into their psychological problems through the mechanism of role-playing and interpretations made by the therapist. (See *Group Psychotherapy*.)

Do hobbies contribute to mental health?

The consensus of psychiatrists is that hobbies can contribute greatly to mental health. One of the many definitions of the word "hobby" is that it is a favorite pursuit carried on with enjoyment during leisure time. Although the pleasure and absorption of interest may be its own reward, the hobby also allows for the reestablishment of poise and the reintegration of the personality after a day's work—an important characteristic of all recreation.

There are approximately two hundred recognizable varieties of hobbies in the United States, of which collecting is the most popular. Hobbyists tend to be particularly enthusiastic about the wonders or values of their individual hobbies. Psychiatrists are aware of the value of hobbies in maintaining mental health; not only do hobbies provide socially approved outlets for unconscious drives, but also they may offer an opportunity for the process of identification, both individual and within a group. Hobbies usually are an indication of health; on the whole, normal individuals seem better able to enjoy hobbies than do maladjusted individuals.

Is there a basic difference between the play and recreation interests of men and women?

There are tremendous differences among men themselves as to what is experienced as recreation; also among women themselves. There are men who are very gregarious and women who are very shy and retiring. In fact, within the same individual, from one age period to another, changes take place as to what constitutes play and fun, and what is work.

II. CHILDREN

Does children's play have the same function as adults' work?

It has been said that children's play can be equated with adult work. By this is meant that the main preoccupation of the adult is his work. His life centers around it. It preoccupies his time and interest. The same is true for the child and his play. Eating and sleeping for the child is time away from his play. If he does not play, he does not exercise those inner faculties whose development depends on his play activities. Likewise, if the adult does not work, important faculties within himself do not develop and those faculties that are already developed will atrophy. Thus, we can say that play in the child, and work in the adult, are essentials for continued growth and development of the human individual in both physical and emotional areas.

Does children's play serve any functions other than pleasure?

Children's earliest play has the function of simply providing pleasure. Play, in children, is also experienced as a learning process. The child grows into his social environment by learning to adapt, to overcome obstacles through skill and intelligence. But this is a gradual process, best developed in relaxed, encouraging, external play situations before being tested under the comparatively severe, threatening conditions of reality. When the external situation contains threatening demands, play is used by the child to convert the reality demands into a pleasurable setting in which he, instead of being overwhelmed, becomes the master of the challenges.

Children repeat in play those situations that threaten their emotional equilibrium in actual life. For example, suppose a child has just returned from the dentist, where he had to submit passively to what he considered a very painful and terrifying experience. He might then take a sharp instrument and make holes in materials such as wood or

dolls; he might even maintain his interest in this type of activity for days. Thus, in his play, he mitigates his conflict and recaptures for a while the omnipotence he once believed he possessed. His play has helped him to overcome a specific fear. Children minimize the disturbing force of their experiences by making themselves, through play activities, feel like masters of the situation. Play thus helps the child to explore and master more and more segments of reality, the mastery of which is the essential ingredient of mental health.

Margaret S. Mahler states, "The word 'play' connotes that emotional quality of childlike activity, one might say creativity of the weak ego, which is the exact opposite of the dreaded massive impressions, to which the world of reality subjects the child's senses as passive receptors, traumatically overwhelming him."

In addition, the pattern of play offers children a substitute for those activities that are unacceptable to the adults in the environment. For example, children's desire to play with feces and to soil themselves is sublimated into playing with clay, making mud pies, and finger painting. Masturbatory stereotyped habits are sublimated into use of playground equipment such as slides, swings, and hobby horses. Hostile urinary impulses are more acceptable if expressed in play with water guns. Thus socially unacceptable or even harmful stereotyped habits can be exchanged for acceptable and better sublimated activity through play.

A child expresses himself in play more than in words. Being a child, playing, having fun, serves the vital function of expressing feelings, which is a method of being and becoming oneself as distinct from others.

In play, the child may also be able to deny, lessen, or master the anxieties accompanying each close emotional relationship. Lili Peller stresses that later play has the function of achieving a compromise between the demands of inner drives and the dictates of reality. This play can be categorized according to the object of the child's anxieties (body, mother, father, siblings) and the compensating fantasies.

The later function of play is a learning process. It helps the individual to master both the environment and the internal disturbing reactions. In adolescence, play serves the vital function of learning how to compete well with other people. It is also used as a means of establishing one's separate identity and individuality, as distinct from others. Games now become a preparation for the soon-to-be-experienced adult way of life.

What is the fundamental feature of children's play?

Freud believed that the child, in play, is mainly motivated by the impulse to gain mastery of a situation. Erik H. Erikson illustrated this through play therapy with children. Robert Waelder corroborated this view when he explained play activities in which the child repeats past traumatic painful situations. In play the child attempts to master not only external dangers, but also internal conflicts. For example, let us suppose that a child has suffered the trauma of the death of his mother. In his play therapy he may take a doll and love it and hug it and kiss it and mother it over and over and over again. This will be repeated until the painful experience has been overcome and mastered through the play therapy. It is an assimilative procedure that operates by repetition. The doll represents the child himself, and the child plays the role of the lost mother and does to the doll what was lost to him by the death of his mother. Mourning belongs to the group of assimilating processes.

Playful problem-solving activities give play its distinctive feature, since there is no pressure for immediate solution to the problem, as is present in a dangerous reality situation; but achievement of mastery is fundamental to children's play activities.

Do children's play activities differ according to the age of the child?

Maturation of sensory and motor capacities, although somewhat variable in each child, proceed in a predictable chronological order. For example, in the first six months of life, sensory experiences such as seeing, touching, and listening are predominant. The infant's play interests during this period are concentrated about these perception centers and are facilitated by infant mobiles, musical boxes and records, dolls, beads, and rattles. Most babies spend their waking time in looking, listening, touching, and practicing motor skills leading to new mastery of their bodies or of the environment. Thus, the period of six months to a year is one of exploring newfound textures and beginning simple manipulative tasks with stuffed animals of various textures, balls, and toys with movable parts. This play includes both humans and inanimate things as exploratory objects. The first-year child learns through sensory experience to develop his powers of observation and discrimination in order to form meaningful concepts of the many different objects in his environment.

Infants begin to solve problems very early so that, during their second year, many of them can carry out fairly complicated tasks, such as put-

ting together hollow blocks, making small towers or bridges, fetching an object and transferring it from one location to another. Pushing, pulling, and climbing are desirable activities for the one- to two-year-olds using slides, stairs, blocks, or a rocking horse.

In sharp contrast is the two- to eight-year-old child, whose world of play centers around family relationships. The child engages in role-playing wherein the home situations are reenacted. These are the years of peak imagination. Both boys and girls play the role of baby. Three- to six-year-old boys, as well as girls, become absorbed in the "playing house" type of activity, with miniature furniture, miniature cooking utensils, giant-size or any size dolls and buggies; also in playing business, using toy cash registers, money, and telephones. This type of play helps them to master the family living problems predominant in this age-group.

At this period the child also plays with cooperating adults. From infancy on, any type of activity that involves an interpersonal relationship such as playing peekaboo or throwing a ball back and forth or an adult supervised game, necessitates the child's healthy participation. Such interpersonal play has the significance of being the unique situation in which his participation is as important as that of the adult. His equal need to master this type of relationship through play is paramount to a relatively anxiety-free grasp of reality of the object world.

The older age-groups of children cannot be divided so conveniently into specific sensory areas of development inasmuch as all of their faculties are developed and ready for stimulation. Toys can then be divided into areas of world activities, which can be mastered through play. Community play would use toys like unit blocks to build cities, etc. Blocks vary in size for different age-groups. Sculptured wood figures contribute to community play. Of course, trains and cars and planes involve the world of transportation.

In still older age-groups, children can learn of our growing knowledge of this universe through science toys. Chemistry sets, microscopes, and anatomical sets, stimulate the natural curiosity of our future scientists. Musical toys can become the first step toward introducing music lessons to the creative child. For children in the teen-age years, however, I would be very careful about suggesting toys. Teen-agers are entering the world of adults and are beginning to use full-size objects and to participate in real situations. Parents' help at this time is usually not accepted even if it is desirable.

Are play materials helpful to the child's play?

Sufficient and appropriate play materials allow the child to create a scaled-down toy world of his own, shaped in the image of the community that he observes. He thus can create in miniature and in simplified forms what he has seen but not yet fully understood or related to or mastered. By reproducing over and over again with toys what he is trying to understand, he can experiment with several possible solutions to the problems he is thinking about. Toys designed with careful attention to their educational purpose serve a useful function in the child's learning. Play materials that stimulate the child's mind and offer the possibility of creating or constructing something contribute to the child's healthy interest in later learning experiences and challenging problems. Building sets, manipulatory toys such as hammer and pegboard sets, parquetry blocks, landscape peg sets, building blocks, and puzzles are stimulating toys that allow for architectural creativity.

What accounts for the marked change in school and playground equipment?

Playground architects have developed a new philosophy for designing playgrounds. Current school and playground equipment, like slides and swings, are thought to help "kids change from primitive creatures to civilized people." Functional play apparatus such as the jiggle-ring, the jiggle-rail, and the swing-ring contain an unpredictability that is a margin for inspiration. It is also believed that the most beneficial result of play is learning how to get along with others, and that functional play apparatus requires cooperation among children. In order to have even more of the ingredients of the adult world, play equipment should also be "continuously challenging" and have an "element of unpredictability." Unpredictability, within reasonable limits, is the factor that gives physical activity the creative quality which is the very soul of play.

Learning can be propelled by the wise choice of equipment for the play yard. Children need to develop coordinating, mastering movements and skills, which the handling of play equipment and the performing of athletics demands of them.

Is it possible to tell if a child is emotionally ill by his type of play?

A trained child therapist can do this. Anna Freud, who was one of the first to use play in the psychoanalysis of children, wrote, "Neurotic children are invariably disturbed in their play activity. With certain

types of neuroses imaginative play is excessive at the expense of constructive play. . . . This is sometimes taken as an asset by the parents, as the sign of an especially vivid imagination . . . but the neurotic element is unmistakable when such play becomes repetitive, monotonous, and interferes with all other kinds of activity." Thus, observation of children at play can give diagnostic insight into the personality and the problems of the child.

What is the basis of play therapy for children?

The problem-solving element in play is used in play therapy. The abreaction (emotional release or discharge resulting from recalling to awareness a painful experience that has been forgotten) of surplus tension is recognized as one of the mental health promoting functions of children's play activity. The permissive atmosphere of the therapy situation encourages the child to express his problems in his play. The therapist's main function is to aid the child, at the play level, to work out problems when the play becomes unsuccessful. Erikson states, "The therapist accomplishes this by inducing the children by 'systematic interpretation' to reconsider, on a more verbal level, the constellations which have overwhelmed them in the past and are apt to overwhelm them when reoccurring."

The therapist has an opportunity to take part in meaningful play activity in order to communicate with the child on a natural level and to exert a therapeutic influence within an emotionally significant context.

Is recreation of value in a program for mentally retarded children?

Yes it is, although the activities of mentally retarded children may need to be simpler than those provided for normal persons of the same age-group. Mentally retarded children are capable of participating in group activities. The problem is that recreation has been an area of neglect in hospitals devoted to their care. Recreation provides wholesome and purposeful stimulation and enjoyment for the mentally retarded. Some recreation activities have diagnostic value in the study of this group.

With some children, particularly those with a handicap, there is a special need for constancy and for familiar routine in all their activities, including play. These children are more threatened by new and unfamiliar activities. This need, if respected, can be used constructively in the development of reality testing and ability and willingness to

learn. Fun and play can be used to help the retarded child toward achievement of these goals. The retarded child is one whose appetite for stimuli and for new impressions needs to be awakened, and whose confidence in being able to derive pleasure from new and unfamiliar perceptions must be encouraged.

What kind of play is suited for the handicapped child?

The type of play for the handicapped child is not the important factor, but his attitude toward play is important. The playful quality of fun should be consistently encouraged in all activities of such children. The weak ego of the child necessitates small, graduated, pleasant doses of reality such as is possible in play as opposed to the harsher world of reality. As these graduated doses are assimilated, the ego, instead of being overwhelmed, continues to grow. Margaret Mahler states, "The difficulties of handicapped children also appear in their play activity. They must be steered between the extremes of passive inactivity and their tendency to maintain their belief in their magic omnipotence by their endlessly repeated stereotyped activities and gestures."

POLITICS AND MENTAL HEALTH

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What is politics?

Politics is formal and informal government at all levels—local, state, national, and international. The participants in the political process include governments, political parties, pressure associations, and individuals who devote themselves to public affairs.

Does politics influence mental health?

Yes. For example, we know that mental health is influenced to some extent by crises, and that many crises are political. In the broadest sense, politics includes wars, revolutions, rebellions, and elections. (See *Emotional Crises*)

Does mental health affect politics?

Politics is affected by the mental health of leaders and of those being led.

Were some historical leaders mentally ill?

The great empires of the past—Egyptian, Chinese, and Roman—occasionally had emperors who were mentally ill. Today we can diagnose their afflictions as, for example, epilepsy, schizophrenia (paranoid type), or severe melancholy. These emperors were often dangerous to themselves and to others. A guide to the diagnoses that have been made of famous historical figures is found in Wilhelm Lange-Eichbaum's book on *Genius, Insanity, and Fame*. A collection of concise case summaries is in C. S. Bluemel's book, *War, Politics and Insanity*. (See *Paranoia; Manic-Depressive Psychosis; Schizophrenia; Epilepsy and Other Paroxysmal Disorders*)

Have more recent leaders been seriously ill?

One notorious case is that of the late Joseph Stalin, whose later years of tyranny were, in part, a result of mental disorder. He became

morbidly suspicious of others and sought to destroy them before they could destroy him. The pathological traits of Adolf Hitler and of some other Nazi leaders are well known. They are described in G. M. Gilbert's *Nuremberg Diary* and in John R. Rees's (ed.) *The Case of Rudolf Hess*.

Are democratic leaders immune?

It is true that the top leadership levels of nations long accustomed to constitutional and representative government have been free of Stalins and Hitlers. The openly competitive arena of democratic politics does not encourage them. However, as we shall see, mental illness is no respecter of political institutions.

Are agitators and fanatics mentally ill?

Many political movements bring to the top individuals of passionate intensity of conviction and of agitational skill. The persecutory agitator, for example, is a specialist in arousing fear, suspicion, hatred, and vindictiveness. Often the campaign is directed against foreigners, or persons of a minority race or creed. It is not uncommon to discover in such leadership groups, psychopaths and borderline psychotics who find it easy to act out their destructive tendencies. Case histories of agitators are to be found in Harold D. Lasswell's *Psychopathology and Politics*. A distinction between "tough-" and "tender-" minded politicians has been worked out by H. J. Eysenck in *The Psychology of Politics*. (See *Psychopath or Sociopath; Prejudice*)

Are all agitators mentally unbalanced?

No. Agitation is a well-established strategy for getting results in politics. Hence many politicians agitate the people not because they especially enjoy it, but because they recognize the practical advantages of mass appeal.

Are mentally disturbed agitators always destructive?

On the contrary, many social abuses have been corrected, as a result of the initiative and intense conviction of leaders whose pathology is fairly obvious to trained observers. Agitational activity is attractive to some rather disturbed persons who go to extremes to dramatize the self. This is sometimes true of leaders who campaign against such social abuses as child labor or cruelty to animals. However, these crusades are sometimes captured by persecutory agitators who substitute the strategy of coercion for persuasion. In American history the hys-

terical attacks by Carry Nation against saloons is a memorable case. The most instructive and thought-provoking example is the antislavery crusade that culminated in the Civil War.

Are intense convictions a symptom of disorder?

No. The capability of taking a firm position is a mark of good mental health. Intense convictions are symptoms of a disordered mind only when they are unaffected by experience, or when it seems necessary to the individual to express them as offensively as possible. In a free society we take it for granted that differences of opinion exist, and that differences are open to influence through the experience of discussion and inquiry. Genuine discussion and inquiry are repugnant to disordered minds.

Are noncommittal persons particularly healthy?

In some circumstances we expect people to refrain from expressing their opinions. It is obviously inappropriate for a judge to interrupt court proceedings by making statements favorable to one side or the other. The chairman of a discussion is expected to let others speak, and to listen also to points of view of which he does not approve.

Individuals are often too confused or fearful of giving offense to say what they believe on matters of public concern, or they may be unable to come to a conclusion even in the privacy of their thoughts. It is likely that these people are somewhat disordered.

Are revolutionaries always mentally ill?

Definitely not. It is true that during the early stages of a revolutionary and radical movement the cause draws heavily from deeply disturbed personalities. A famous case is that of Sergei G. Nechayev, an anarchist and activist, who glorified conspiracy and assassination. Fëdor Dostoevski drew minutely detailed portraits of rebellious sons and revolutionaries in his novels. The dynamisms have been expounded by modern psychiatrists (for example, Robert Lindner in *Rebel Without a Cause*). As a movement gains wider support and wins acceptance for new norms of conduct, both leaders and followers are recruited from all kinds of people.

Are political conformists always healthy?

No. Extreme conformity is often a symptom of deep-seated mental trouble. The individual is trying to keep himself under control by exaggerated adherence to an established body of doctrine and code of

conduct. Mechanisms of rigidity are conspicuous among obsessional and compulsive neurotics, and "authoritarian" characters. The tendency to project blame upon others, and hence to attack scapegoats, is part of the picture that has been drawn in detail in the researches of T. W. Adorno and associates in *The Authoritarian Personality*. (See *Neuroses*)

Are administrators notably sound of mind?

Administrators often show a smooth front. They do not appear to agitate others or to express vehement personal opinions, but this does not necessarily indicate that their mental health is notably good.

Many routines of an administrative career are congenial to individuals who suffer from mental difficulties. Responsible administrators are expected to enforce a body of rules found in legislative statutes and in codes of official regulation. It is assumed that they perform their duties in prescribed ways, and make precise reports. But it is possible for destructive characters to tyrannize over others in the name of rules and regulations. Persons who are fearful of allowing themselves to understand other people may use red tape to keep the needs and problems of their fellowmen at a comfortable distance. The more we study bureaucrats, the more likely it seems that the well-known difficulties of bureaucracy often reflect the mental health problems of officials.

What can be said of the mental health of judges?

Judges are professionally trained and experienced, and we expect them to give deference to general rules and precedents. In order to guard against the pressure of special interests, judges are often appointed for life. These factors may insulate a judge from the thoughts and sentiments of the "common man." Another result may be to increase the risk of mental disorders associated with aging, such as impatience with change, inability to focus attention, and an exaggerated sensitivity to personal slights. It has been difficult to devise a dignified method of removal that at the same time protects the independence of the judiciary. For case histories and a discussion of some problems affecting the courts, attention is called to Jerome D. Frank's *Law and the Modern Mind*, and H. D. Lasswell's *Power and Personality*. (See *The Senile Psychoses*)

Are the police inclined toward sadism?

The administration of the law depends upon the mental balance as well as the professional skill and honesty of police officers. Police

duties are necessarily carried on under the shadow of violence. At any moment, routine may be punctuated by a band of armed robbers or a desperate murderer, or by a drunken brawl or a teen-age clash. As a defense against cumulative fear of death and mutilation, some police take pleasure in inflicting cruelty upon others.

Is the mental health of the military ever affected?

The character of modern war has made it less likely that all members of the armed forces will engage the enemy in hand-to-hand combat. However, it is obviously necessary to provide combat training even in peacetime, despite diminished motivation on the part of trainees. Many combat specialists feel obsolete and defensive, and, therefore, find it difficult to avoid "taking it out" upon relatively indifferent trainees. In general, the simpler forms of cruelty are disappearing from the armed forces of industrial powers.

Are political police especially prone toward cruelty?

Political police are responsible for checking on the loyalty of civil and military officers and personnel, and of other members of the community. They also guard against espionage and sabotage by agents of foreign powers. Hence they operate in great secrecy and are often in danger of assassination. They believe they are at war even in times of formal peace, and feel free of many ordinary restraints. These factors help to explain the frequent use of brutality. They also help to account for the attractiveness of political police work to persons who are prone to cruelty. These disordered personalities are often described in studies of concentration camps or camps for prisoners of war. In this connection consult Bruno Bettelheim's *The Informed Heart: Autonomy in a Mass Age*. Everyone has heard of the systematic terror conducted by totalitarian powers. It is not so widely recognized that today the political police function is also a regular, though a minor, activity of popular governments.

Are jailers disposed toward cruelty?

In the past, prisons and jails (like the old "insane asylums") were staffed by persons, many of whom were themselves on the borderline of mental disorder. Some of them were evidently fascinated by the opportunity to treat others with the contempt and hatred that, fundamentally, they felt for themselves.

Do modern agencies of correction still have critical mental health problems?

A determined effort is being made to build correctional agencies that prepare convicted persons to become useful members of the community. The type of personnel formerly used—ignorant, cynical, cruel, vindictive—is being replaced, but correctional institutions still have mental health problems of dismaying proportions. (See *Correctional Institutions and Psychiatry*)

Is the use or approval of violence a sign of mental illness?

Most emphatically not. Lawful force is an established institution of public order. A suspicion of pathology is justified when violence is initiated or supported with exceptional zeal and enjoyment.

Is the refusal to use violence a sign of mental health?

Not necessarily. When individuals have been reared in a culture that approves the use of force for lawful purposes, refusal to use force when obligated to do so may be a symptom of mental disorder. Some religious groups have a tradition of nonparticipation in violence, and persons who have been brought up in this tradition are acting "normally" when they refuse to kill others. The most difficult problem is presented by an individual who has received no special training in norms of nonviolence, and claims to have come to this point of view on his own responsibility. We recognize that new convictions can be adopted by sincere and mentally well-balanced people. The problem of recognizing a genuine attitude arises when the conversion is sudden and when the individual is in a position to gain advantages from it, such as exemption from combat. For American experience with these questions, one may turn to Julien D. Cornell's *Conscience and the State*.

Is it possible for political assassins to be mentally sound?

Yes. Assassination is a common strategy of some political movements and is not necessarily carried out by a mentally ill person. It is known, of course, that many assassins or would-be slayers of political figures are gravely disturbed psychotics. Such a one attempted to shoot the late President Franklin D. Roosevelt and actually fatally shot Mayor Anton J. Cermak of Chicago. Not all members of the conspiracy to kill former President Harry S. Truman and other United States leaders, plotted as a gesture on behalf of Puerto Rican independence, were mentally ill.

Are spies and saboteurs mentally sound?

For many devoted nationalists or revolutionists a career of undercover work is an act of service and indicates no pathology. However, many unbalanced minds are strongly attracted by these occupations. For mercenary spies and saboteurs, "it's just a job." Mercenaries often are psychopathic characters who have never identified themselves as loyal members of any group, and feel no obligation to serve collective goals.

What is the pathology of political mobs?

We distinguish between the political strategist who plans and manipulates mob action, and the individuals who are caught up in the excitement and intolerance of a crowd in action. The experienced political manager may be emotionally uninvolved throughout the operation, even when he incites a milling throng of demonstrators to destroy a prison or lynch a prisoner. It is well known that in the anonymity of a mob many individuals lose self-control and allow their primitive impulses to have free sway. It does no violence to language to say that such people then suffer from temporary mental aberration. (See *Mass Hysteria*)

Are all political crises largely nonrational?

There is no doubt that people are likely to act very differently in times of crisis than at other times. We often look back with surprise at what we did in the heat of an election campaign, or a war scare. Specialists on mental disorder are reluctant to apply clinical labels like hysteria or psychosis to collective acts. The clinical terms refer rather clearly to persons who deviate from the norms of the people immediately around them. In many collective situations the norms of nearly everyone change at the same time. Thus, every member of the national public may believe that Nation A will attack at once; or that the country will be ruined if the other party wins the election. In a few days or even hours it may be obvious that everybody was in error and that there had been a collective suspension of critical thinking. This, in a way, is a departure from mental health.

Should we speak of "unrealistic" or of "unhealthy" thinking when referring to emotional crises in politics?

It is admittedly difficult to draw a line in these matters. When everyone is stimulated by the excitement of a fund-raising dinner and pledges more than he can afford, it is easy to admit the next day that

everybody was temporarily deranged. Suppose, however, that a political crisis continues for days or years. Is it sensible to say that collective beliefs were nonrational for so long? Or shall we speak of "unrealistic thinking" short of aberration from mental health?

Today even the experts do not agree on these matters. But the issues are clear, and the reader is invited to make up his own mind. A helpful guide to the fragments of scientific information at hand is Robert E. Lane's *Political Life: Why People Get Involved in Politics*.

Can the rise of disordered leaders and outbursts of political destructiveness be prevented?

This question gravely concerns the future of man. Since the most disastrous examples are closely connected with war and preparation for war, it is clear that the prevention of war is the problem that most imperatively demands solution. (See *War and Mental Health*)

It is, however, recognized by political scientists that destructive leadership is largely a reflection of the opportunities created by destructive situations. This is the sense in which power is an interrelationship: to wield power is to *be empowered* by passive acquiescence and active consent.

Therefore, whatever situations in the life of a culture, a social class, an interest group, or a personality dispose the persons involved to act destructively is an invitation to destructive leaders to rise from modest to imposing positions in the arenas of politics. The corollary is that whatever can be done to reduce the dispositions and the occasions for destructiveness is a contribution to the politics of prevention.

What strategies of prevention are possible?

Many suggestions have been made for procedures to reduce the chances that destructive persons will rise to positions of leadership. It is proposed, for example, to use psychiatric examination and psychological tests to identify dangerously destructive individuals, and either to provide for their cure, or to interfere with their careers. Great hopes are pinned to the spread of public education in mental hygiene in the expectation that the community at large can be alerted to detect and reject as leaders all who show disturbing symptoms. The mental health movement is itself an attempt to reduce the strength of predispositions to act destructively. An ultimate goal is to contribute to the insight and understanding that prevail among the leaders and those being led throughout the world. (See *Psychodiagnostic and Personality Testing*)

POPULATION CONTROL AND MENTAL HEALTH

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What is population control?

Population control is the exercise of methods to influence the rate of reproduction of a population. Population control may operate in the direction of increasing the number of individuals, or decreasing the number. Increases in populations have been sought for many reasons. Perhaps the first is a philosophic notion that a country or a population is in a healthy state only when it is growing, and is looked upon as stagnant or deteriorating when it remains stable in numbers or decreases. The second is that in a world whose history has been dominated by wars, a supply of manpower for fighting has been a desirable end and increases in population have been sought to achieve this. Finally, new countries with unexploited resources need people to bring them to full productivity, and these countries seek to expand their populations to achieve this end, either by encouraging immigration of large numbers of people from areas oversupplied with people, as the United States did until recent decades and as Australia is doing today, or by urging families to produce more children, either by propaganda means or by granting direct or indirect subsidies for the support of children.

Although infanticide, particularly female infanticide, coitus interruptus, and abortion have been practiced in some cultures since earliest history, the relation of these practices to scientific thinking about population control in general is not clear. The ancient practices were so deeply involved in other considerations within the culture that it is hard to be sure of such questions as when was population control the basic concern and what part of the practices were more related to religion, to the control of individual sex practices, and so forth. Modern thinking about the control of populations awaited the developing of communications systems and the knowledge of statistics that could deal

with the problem of calculating food supplies and the number of people to eat them.

Although local famines have been recognized as representing a disproportion between the supply of food and its consumption, only in recent times has it been possible to look at this problem from the point of view of world population and world food supply. Statistics now make it possible to estimate the rates of growth of the world population and to compare this with the possible rate of growth of the food supply. The conclusions arising from this work have proved alarming. Many scientists have come to the conclusion that mankind must control its numbers, inasmuch as the supply of land cannot be expanded. The rate of population growth is, in the opinion of these persons, much greater than the rate of increase in food production can be, even if an optimal distribution of available food and the land to produce it is assumed.

What is the history of population control?

Control of populations in the lower animals is very old in human history. Flocks and herds can be made to increase by suitable breeding, and a balance between food supply for, and food consumption of, animals is struck by every farmer who estimates how many cows can be successfully grazed in a given pasture.

Mankind has also attempted, with increasing success in recent years, to decrease populations of pest insects and animals. Draining marshes to cut down mosquito populations has been carried out for centuries. In a highly sophisticated way the control of water levels behind the Tennessee Valley Authority dams was used to ensure that an increase in mosquito population (and the spread of malaria that might have accompanied it) would not offset the flood control, water power, and navigational advantages of that river valley development.

Population control of pest insects is also very closely related to food supply for man; for example, the population control of rats not only prevents transmission of certain diseases but also cuts down on the rats' competition with man for the world's food supply. Population control in animals and insects is well known and has been for centuries. It is a part of the warp and woof of agriculture.

Man has known for many centuries that his rate of reproduction could be influenced. As already noted, when the world was underpopulated and much of it unexploited, there appeared to be a need for more people. This need found expression in many religions of the world; the

Judeo-Christian expression is the Biblical admonition to Noah, “. . . to be fruitful and multiply.” Thomas Malthus, a British clergyman who died in 1834, was the first person who aroused controversy by his argument that there might be danger for mankind in carrying out the admonition literally. He predicted that populations would grow faster than their food supply, and that only starvation and excessive poverty could result unless man decreased the birthrate. Malthus advised that late marriage and sexual continence could be the means for reducing the birthrate. In modern times, many more ways for the control of the reproductive rate have been developed and are being widely used in parts of the world and by some segments of the population.

What forces or organizations are in favor of population control?

The popular conception of population control is that it means reduction of the rate of population increase. Population control tends to be identified with “birth control,” although the concept is really much broader than mere population limitation.

In general, reduction of the rate of population increase is agreed to as necessary by persons and organizations who take a rational view of man and his place in the world and the universe. However, a considerable portion of the population believes that mankind is not subject to the laws of nature as are other animals, and maintains that a supernatural “Power” will provide for all children produced by the reproductive mechanism created by this Power. The issue that is more divisive appears to be not the need or desirability of controlling the rate of population increase, but rather the acceptability of methods for achieving this end.

Here people appear to split into two fairly distinct groups so far as stated beliefs are concerned, the one appearing to believe that any medically sound means of control of reproduction is acceptable, the other believing that only methods of birth control which involve control of the frequency and timing of sexual intercourse can be morally defended. In practice the two groups do not appear to be as distinct as they are in statements.

What is the attitude of the medical profession toward population control?

The medical profession is not uniform in its attitudes toward population control. Physicians belong to various religious and political groups that have radically differing opinions on many matters. On the

other hand, physicians are highly educated people and tend to have opinions like those of the educated groups in the population. As such, they take a rational view of man more often than not, and a majority of them probably tend to favor population control.

As practitioners of medicine the majority of physicians probably favor birth control as a means of population control. Depending upon their personal religious views, they may recommend methods that include complete or partial continence or other means of control. Perhaps physicians are more realistic in their views of what can be expected in the way of continence than others in the population who know mankind less intimately.

Mental health personnel are perhaps better acquainted with the effects of fatigue, poverty, thwarted opportunity, and other frustrations that bring stress to many families in which there are too many children. Mental health personnel are probably more conscious of the social reasons for the need for birth control than are physicians and professionals in other fields of health.

What forces or organizations oppose population control?

There are few large organizations that stand in direct opposition to population control. The Roman Catholic Church strongly opposes any interference with the conception of a child at intercourse, but it does not oppose control of family size by continence or by controlling the time of intercourse so that it comes only when the female is in an infertile period of the menstrual cycle.

What methods of birth control are available and what are the medical attitudes toward them?

There are many methods of preventing the birth of a viable child. Though not all will be discussed here, all known methods may be related to the following general categories:

a) Coitus interruptus: the withdrawal of the penis from the vagina before the spermatic fluid is ejaculated. This is perhaps the oldest method of birth control. It is specifically condemned in the Bible. Psychiatrists and other physicians, in general, agree with this condemnation, concluding that the interruption of the sexual act before the full satisfaction of both partners is not health promoting.

b) Sterilization: for purposes of birth control, sterilization has the advantage of absolutely preventing conception without further action. Although the cost of the operation is high, it is a one-time cost and

may, therefore, be within the financial possibilities of a family. It has the disadvantage of being practically irreversible. The Catholic Church condemns it as a means of birth control, though it appears to be widely used in some Catholic countries. Operations that sterilize as a necessary incident to the treatment of physical diseases are not disapproved by the church. In general, sterilization, when the family is completed, is approved by non-Catholic groups.

Sterilization may be of either the male or the female. The operative procedure for the male is relatively minor and is increasing in popularity, particularly among educated groups. Sterilization of the female is much more common in almost every culture, however, even though it requires a more extensive, major operative procedure.

c) Contraceptives:

1) the "condom" is a thin rubber sac placed over the penis before intercourse, and has been in use for centuries in various forms. It is a relatively effective method of prevention of conception. It is, of course, condemned by the Catholic Church as a mechanical interference in coitus. It has no medical contraindications. It requires consistent use in every act of intercourse to prevent conception; this is a disadvantage for people who cannot control their sexual drives even to this extent. The use of condoms can be a relatively inexpensive method of contraception, but usually is not, because of the semi-illicit ways condoms are sold.

2) the "diaphragm" or cup is an appliance that occludes the opening of the uterus and prevents the passage of the sperm. Used with a spermicidal preparation, it is considered to be the most effective method of birth control. It requires consistent use to be effective and is relatively expensive. This method is disapproved by the Catholic Church.

d) Spermicides: chemicals that cause the death of the sperm in the vagina. There are many chemicals that will make sperm infertile if they come in contact with them, and that do not harm vaginal tissue. These chemicals, combined with a jelly or cream base, are placed in the vagina before intercourse. They are probably not as effective as the condom because they may not be used properly and thus do not come into contact with the spermatic fluid directly. Like the condom, they require consistent use, but by the woman rather than by the man. Spermicides are more expensive than condoms generally and the cost is continuous. This method is considered outside the range of possibility for poverty-stricken populations. There are few medical contra-

indications to carefully prepared products. The Catholic Church disapproves of this method.

e) The safe period: the timing of intercourse so that it occurs during the time of the menstrual cycle when the woman is infertile. This method has the qualified approval of the Catholic Church. There are no medical contraindications. This method is among the least reliable inasmuch as menstrual cycles are not wholly predictable, and it requires that the marital partners have considerable knowledge and self-control. Since no apparatus is needed, this method is, of course, entirely possible from the financial point of view. It requires the ability to keep close track of the passage of time and a willingness to give attention, which has proved difficult to obtain in uneducated populations.

f) Abortion: the emptying of the uterus early in the pregnancy. This method of birth control is the most strongly condemned by the Catholic Church and by many other groups. It requires excellent medical care and considerable skill if the necessary operation is to be safe. It has the disadvantage of needing to be repeated during each pregnancy. Despite the great disadvantages, it is used widely in the United States, mostly illegally, and often by persons not medically qualified. Legally, it is used exclusively by ethical physicians only in cases in which completion of the pregnancy would result in very grave consequences to mother or child. Abortion by approved medical authorities is legalized in Japan as a means of controlling the population of that overcrowded country. (See *Abortion*)

g) Hormonal and drug methods: the control of fecundity by hormones and drugs. As yet no proved successful method of administering such substances has been developed for use on a large scale. There is much research going forward, however, and there are strong indications of probable success. The objective here is, of course, the development of a substance that can be taken by mouth, that suppresses fecundity, and that does not interfere with pregnancies when the partners wish to produce a child. An additional desirable quality is that the substance be cheap enough so that it can be within the reach of people who are very poor.

h) Methods involving restriction of coitus: control of the frequency of the sex act, assuming this control to be within the power of the group of individuals concerned. It is said that the pattern of late marriage in Ireland, based on virginity prior to marriage, is a method of population control. Continence within marriage is also a method of birth control. Many authorities believe that the human being cannot be

expected to exercise this kind of birth control, and it has been suggested by some that, in general, sexual continence is not consonant with optimal health, although there is little scientific evidence on this point.

Do postal regulations and state laws affect population control?

Population control obviously is related to the sex act. In many societies, including the United States, coitus outside the marital relationship is considered reprehensible and is to be discouraged by every means possible. The threat of pregnancy is considered one means of discouraging illicit sexual relations, and the lessening of this threat by disseminating knowledge about birth control is, therefore, considered immoral and interpreted by some as obscene. This line of reasoning underlies the federal postal regulations and the state laws that make the giving of birth control information illegal. There is no question that these laws and regulations deprive many legally married couples who wish to practice birth control from getting sound information on methods for accomplishing this. In some states the physician may be enjoined by the law from exercising his full medical judgment in advising his patients.

Who is interested in population control in the United States?

The first to be mentioned are the scientists interested in population trends and the world's food supply. These men are generally connected with the medical specialty of public health. They point out that medical advances of the last century have greatly reduced death rates but have left birthrates undisturbed. Not only has this directly and immediately increased the population, but it has made possible a very rapid rise in the *rate* of increase, since more people of reproductive age are consistently available for reproduction. Many of these scientists are profoundly alarmed at the present rate of growth of the world's population, which has been called the "population explosion," and foresee in the relatively near future an overcrowded world that cannot produce food enough for its population.

There are voluntary organizations in the United States that try to make information regarding population control available to the public. Perhaps the largest and most important is the group of practicing physicians and medical specialists whose religious convictions do not interfere with this part of their medical functioning. Certain voluntary health organizations also support the ethical distribution of birth control information, collecting money from the public for the support of

clinics where, under careful medical guidance, birth control information is made available at low cost to the recipients.

These organizations are concerned not only with birth control, but also with the equally difficult problem of helping couples who want (but are unable) to have children, to have families. Their birth control activities usually get much more publicity than their efforts to promote fertility in childless couples.

On the other hand, birth control and promotion of fertility are greatly hampered by the legal restrictions already referred to. Rarely is an official health department permitted to house birth control clinics, and extremely rarely are official departments allowed to support programs in this field in the United States.

The need for birth control in the countries where food is never ample is most obvious, but there is great opposition to the United States government lending or giving funds to underdeveloped countries to help them solve their population problems.

The voluntary health organizations supporting the movement for planned parenthood in the United States are neither very large nor very well supported financially and are thus able to make their services available only on a small scale. The reasons for this are not hard to find: people who support them must withstand the weight of the organized public opinion of Catholic and other religious groups, and are likely to become involved in ideological controversies. The organizations are frequently barred from membership in community chests and united appeals and must consequently raise their contributions in ways that are less dependable and more expensive. Frequently these organizations are barred from the coordinating agencies of health and welfare organizations because of opposition by Catholic and other religious groups.

The organizations are generally supported by only a small segment of the population, but the supporters are usually well informed and insist on high medical standards in their clinical and educational activities.

Does the situation in the United States differ from that in other countries?

In countries where there is no large religious group standing in opposition to birth control the situation is far different from that in the United States. There is no significant religious group opposing birth control in India, for example; the problem there is mainly an

economic and educational one, and it is being attacked actively by the government. In Japan there has been a decrease in the birthrate. Although there is doubt about some of the methods used in Japan, the freedom of that country to face its population problems in a rational and scientific manner is very different from the situation in the United States. To walk down a street in Tokyo and see a large sign proclaiming a clinic offering birth control information is quite a shock to an American accustomed to being forced into an almost surreptitious exercise of his convictions about the need for planned parenthood.

How successful has the issuance of contraceptive devices been in averting population problems in backward countries?

There has been very little success in controlling population growth in the most underdeveloped countries. The reasons are many, but perhaps the most immediate one is the cost of contraceptive devices as now available. A second problem is the ability of the population to use devices furnished. Education must be intense and persistent, and this also is expensive. Attempts to furnish devices to keep track of dates so that the "safe period" method might be successful have failed because of lack of education and also because some women are so constantly pregnant that they never find out what their menstrual cycle really is, and, therefore, cannot predict the "safe" periods for intercourse. The menstrual cycle is, furthermore, less predictable in women who are poorly nourished.

In countries that have more medical personnel, such as Japan and perhaps Puerto Rico, population control has been achieved in varying degrees.

Has research produced any new contraceptive devices that require little education?

The production of an inexpensive, effective, medically safe contraceptive is being approached, and several large field studies on new products are under way with definitely encouraging results. It is too early to be sure that the new products will be satisfactory, but there is certainly encouragement to be found in the present experiments. The problem will not be completely solved by the new "pills," but certainly it will be easier for people to avoid burdensome pregnancies than with the devices previously available. Any method of contraception requires foresight and planning; in populations where the level of subsistence is so low that foresight and planning are almost always frustrated, it

will remain difficult to teach the use of contraceptives. Nevertheless, the more uncomplicated the procedure, the greater the likelihood of success in controlling population growth.

How does population control affect the mental health of individual families?

The basic principle that underlies mental health authorities' concern for population control is the simple statement that everyone has a psychological "breaking point," and that efficient and comfortable functioning of families cannot exist when that breaking point is passed for any member. Families are subject to many different kinds of stresses, and each family feels them differently, depending upon the personalities living together and their reaction to each other, their physical conditions, their financial resources, and so forth.

If the world were large enough to provide food for an unlimited population, and if everyone had the resources to get a sufficient share of it, and if everyone could manage a complicated household with many members, perhaps the mental hygienists would not be concerned if all women produced all the children they were capable of producing in the ages from thirteen to fifty. However, in *Man's Capacity to Reproduce*, by J. W. Eaton and Robert J. Mayer, a population is described wherein food supply, housing, and clothing were ample. This population produces an average of ten children per married woman—a remarkable population in that it is one of the few where women are shorter lived than men. It is likely, even in this highly privileged population, that unlimited reproduction is harmful to the health of the women.

Most populations are not so privileged, and most families have to plan carefully how many mouths can be fed, how many bodies clothed, and how many sheltered. In the more developed societies (this will increase rapidly in the less developed as well), an additional consideration must be how many can be educated to the level demanded by modern industrial societies. The strain of seeing children inadequately fed, improperly clothed, and shelterless is certainly an enormous stress on parents, even those whose sensibilities may have been dulled by years of chronic frustration of hopes for improvement in their lot.

Buffeted by poverty and famine and too often unable to control their economic situation, it would appear wise if parents could limit the number of children with whom they must share the inadequate supplies. If family size could be controlled, more children could live to

maturity and the health of survivors would be more robust. Parents then could provide better because their own health would be improved as a result of getting a larger share of the family's food supply. In the privileged countries, the issues may be less acute and the specter faced may be far from starvation or disease, but the fact that parents may be unable to supply needed and appropriate education adds another type of strain.

Raising a family successfully requires a certain level of intelligence. Not all persons are equally endowed intellectually or in management skills. It is likely that the mother of limited skill can manage a family of two or three or four children, but would break under the strain of trying to manage a home with six or more. Many mothers and fathers realize that they are approaching their breaking points but may not know how to limit the number of children and are thus more or less forced into intolerable stress situations. Furthermore, the intensity of the care any mother can supply to her brood must be fractionated each time another individual is added, and intensity of parental care appears to be related to the mental health of the offspring.

Mental hygienists are also concerned about overall population control. Starvation releases some of the deepest aggressive forces of the human being, and population crowding has been the excuse for many wars. The world cannot survive another war. If relief of competition for the world food supply will help prevent wars, the mental hygienist must support efforts that will work in that direction.

In summary, the mental hygienist is concerned about population control so that individuals will not be forced into situations of intolerable stress, so that children will have healthy places in which to be nurtured and to mature, and so that populations will not need to kill others in order to have enough space and food to survive and to live in reasonable security and comfort.

Based on current research, what can be predicted about population control in the near future?

It is to be hoped that inexpensive, efficient, and reversible means of birth control will be developed that will make it possible for poorly educated or uneducated populations to control the number of children born, and that the educational efforts necessary to make these methods effective will become available. It will take time for the education to be accomplished even under the best of conditions and with the best

methods; and it seems unlikely that a slowing of the population growth can be accomplished in the very near future.

Populations are growing rapidly at this time in highly developed countries where the cost of birth control and the education of the public on this matter are not such severe problems. The rates of growth in these countries is, however, far less than in the lesser privileged parts of the world. The present rate of population growth has continued since World War II and as yet shows little evidence of falling again. Probably family size does not place an extreme strain on mothers of the upper and middle social classes. There is ample evidence that they space their children and limit their families regardless of the religious group to which they belong. There are, however, many persons with little schooling who work in less skilled jobs, who do place themselves under excessive stress through producing overlarge families. There is need for birth control information and medical services to this large group, even in the most highly privileged countries.

PREJUDICE

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What is prejudice?

In its broadest meaning, the term "prejudice" simply refers to pre-judgment—judging on the basis of less than complete knowledge of relevant facts when these facts should lead to an opposite judgment. The word, however, has come primarily to connote negative prejudgment—of persons, ideas, or even things. A key feature of prejudice is that anyone or anything belonging (or thought to belong) to the classification receiving prejudice is automatically condemned before any knowledge is received about the individual case. Each member of this classification is bad until proven good. And where prejudice is strong enough, it may be impossible to overcome the initial assumption of badness.

Isn't it natural to be prejudiced?

The tendency to generalize about groups of persons is natural. In countless cases our behavior is based on generalizations from past experience or from information received from others. When persons have certain characteristics, we treat them in certain consistent ways. We behave toward bus drivers in certain ways, toward butchers in certain other ways, and so forth. But while this tendency to generalize may be natural and even necessary, so that we can have some guides in facing new situations, we are not guilty of what is normally considered prejudice unless our generalization is based on inaccurate past information and unless we ignore evidence that the information is inaccurate. For example, the opposition of many whites to Negroes as neighbors is usually a result of prejudice—based on misinformation about such things as the effect on property values. Furthermore, this opposition is likely to be founded on prejudice in that it cannot be overcome even when the individual Negroes involved are, by objective standards, very desirable neighbors. In other words, whites often

show prejudice in the generalizations they make about Negroes as neighbors.

Is this the same sort of prejudice that occurs against ideas or things?

Yes, more or less. The same phenomena of premature and inaccurate judgment and overgeneralization can occur with regard to ideas and things as well as toward people. A new way of farming or of food preparation may be resisted just because "the old way's good enough for us." On the other hand, the novelty of new things, rather than their greater worth, may lead some persons to choose them over established products that actually serve the same function better. In the past, there were religious wars based in large part on prejudice in the form of inaccurate perceptions of the opposition's beliefs and customs. Today, the same often holds true in international relations. Hostilities still feed on prejudice, i.e., against the political and economic philosophies of other nations. And even within nations, antagonisms among political parties stem at least partly from prejudice. Whatever Democrats propose, Republicans will tend to oppose, and vice versa. The opposition often comes without sufficient prior investigation of the proposal; it is not based on truly objective judgment.

Can one oppose something without prejudice being involved?

Yes. Prejudice can certainly be absent from opposition to others' ideas. Much of this kind of opposition is not due to inaccurate or premature judgments, but to accurate perceptions of important differences in underlying values. The term "prejudice" is not usually applied to differing values (differing standards of judgment) themselves. It refers, instead, to fallacious use of values—as where an idea is rejected because of inaccurate notions of how bad it is by the standards of one's values. In prejudice it doesn't matter whether the judgment criteria are commonly shared or not. Instead, prejudice consists of inaccurate conclusions concerning how an idea, person, or thing stands with regard to these criteria.

Thus it would not be prejudice in the normal sense of the word for a person who believes in private enterprise to oppose communism after he learns that the latter seeks the end of private enterprise. (Of course, it really is prejudice for one to oppose communism, capitalism, or any other idea, if one does not understand the idea but just reacts negatively to its label.) Nor would it be prejudice to oppose certain religious

practices which one finds, after investigation, to be in conflict with one's own personal values.

In other words, it is quite possible to have value conflicts without prejudice, just as long as the perceived conflicts are, indeed, real. One should note, however, that realistic value conflicts can lead to prejudices. For example, there are real differences among Catholic, Protestant, and Jewish beliefs, and these differences can at times conflict, as in the issue of public policy regarding birth control. But it is prejudice to generalize one's opposition to include all aspects of the other religion or to extend antagonism against individual members of the religion to contexts other than those where realistic conflict exists.

Let us take one additional example, this one concerning the rejection of particular foods, to point out that negative feelings can be due to prejudice, but that they can also be due to rational application of one's values or even to matters of personal taste. The child who refuses to eat some vegetable without having previously tried it with an open mind is guilty of prejudice. But one may without prejudice prefer one vegetable to another—even to the extreme of refusing to eat the latter—on the basis of having sampled them both before and having developed a definite taste for one and a definite distaste for the other. In matters of taste, as compared with prejudice, there is no implication of "badness" in the thing that is rejected. Finally, one may have certain values—religious and moral beliefs, for example—that lead to a proscription against certain foods. Traditional Jews and Moslems do not eat pork; perhaps no "civilized" man would participate in cannibalism. Such proscriptions are not normally considered prejudice. For, as we have already pointed out, rational application of one's values does not constitute prejudice, even when it may lead to behavior considered bizarre by the outsider.

The area of food choice and rejection is not clearly defined as to where tastes and values end and prejudices begin. But it is a useful example for showing how different factors may underlie any hostility or rejection. We would do well to realize that consequences we may deplore (assuming we share values favoring peace and harmony) can arise not only from prejudice but certainly also from realistic value conflicts, and perhaps even from differences in taste.

In these past two questions, we have dwelt mainly on prejudices against ideas and things. From here on, we shall devote most of our attention to prejudice against persons. This is probably the most commonly thought of kind of prejudice and serves as an example of

prejudice in general. It is also particularly important because of its direct pertinence to problems of interpersonal behavior.

What are some of the ways by which prejudice may be manifested?

Gordon W. Allport of Harvard, in *The Nature of Prejudice*, lists five types of manifestations of prejudice, aside from unexpressed personal feelings of aversion, distrust, and the like. These are (1) antilocution, (2) avoidance, (3) discrimination, (4) physical attack, and (5) extermination. They run the gamut from mild verbal expressions of hostility against a group and its members to the most extreme attempts to end the very existence of whole groups of people.

We have all probably had experience with antilocution in the form of jokes derogating minority groups or statements attributing undesirable characteristics to members of such groups. Avoidance, unless accompanied by antilocution, is not so easily detected, but examples would include the lady who refuses to sit beside a Negro on the bus or the teen-ager who decides not to play baseball when he learns that Puerto Ricans will be on his team.

Discrimination occurs whenever members of certain groups are given treatment differing from that normally given in a particular situation. Even when equivalent treatment may be offered on a separate basis to these group members, it is discriminatory so long as the implication remains that the differentiation is based on belief that the outside group is "not worthy" of normal treatment. Thus, not only is it discrimination to exclude "outsiders" from club memberships and from access to places of public accommodation (restaurants, barber shops, hotels, etc.), but so too are traditional Southern provisions for "separate but (sometimes) equal" schools for whites and Negroes. And it is discrimination to refuse to hire qualified women for management and professional positions, just as it is to have a policy of favoring certain nationalities over certain others in immigration quotas.

Physical attack and extermination are, of course, the most violent manifestations of prejudice. In the former, we include both nonfatal attacks on persons and destruction of property. By extermination, we refer to attacks on individuals or their entire groups for the purpose of inflicting fatal injury, as in lynchings, pogroms, and the Hitlerian attempts at genocide. (See *Mass Hysteria*)

The prejudiced individual may or may not have the potential for manifesting his prejudice in all possible ways. Certainly most are law-abiding. In the United States, this means most would not participate

in physical attack, extermination, or even the severest forms of discrimination. But while antilocution and avoidance are not serious in themselves, they can provide the social support that encourages more extreme expressions of prejudice. Only when it is clear that prejudice is shared by a group is it likely to result in any real injury to the targets of the prejudice. It is only then that discrimination can effectively limit the opportunities of its victims and that physical attacks and worse can be perpetrated with much hope of escaping punishment. On the other hand, the milder expressions of prejudice will often be completely suppressed unless such expression receives support from one's friends and associates.

Do people know when they are prejudiced? Will they admit it?

It is not uncommon for prejudiced persons to deny their prejudice with such statements as, "I'm not prejudiced; why, some of my best friends are [the name of some group], but . . ." What follows is some neat rationalization for an act of discrimination or for a simple feeling of dislike for all members of the named group. One does not want Jews in his club because "Jews are loud and pushy." "Negroes are bad for the neighborhood because they are diseased and have loose morals." It does not matter whether the rationalization may in fact be untrue—as it is for most Jews and Negroes in the above examples. As long as it is believed, it will serve as the justification for prejudiced behavior. In many cases, the justification comes after the prejudice has already formed; in others, the prejudice is a result of innocently received misinformation. But in either case, the rationalization helps to reinforce the prejudice.

This is not to say that many people do not realize that they are prejudiced. They may recognize this and still rely on rationalizations to defend their prejudice. But once it is admitted that the basic feeling is one of prejudice, the chances are more promising for effectively combating it.

Are there different kinds of prejudice?

There are many ways of classifying types of prejudice. We shall discuss only two of the most meaningful typologies here. There are (1) differences in the objects of prejudice, and (2) differences in the types of sentiments that accompany the prejudice. A third typology, differences in cause, is discussed later on.

First of all, the objects of prejudice may vary. As we said earlier,

these may be persons, ideas, or even things. When persons are the target, they may represent a particular racial group, or they may be of a different religion, social class, nationality, or even political philosophy—though with the last, it is often difficult to determine whether the antipathy against an entire group is really prejudice or whether it is the result of realistic conflicts between sets of group values. The choice of a specific group for prejudice is often the product of historical circumstance. But a group's susceptibility to being the object of prejudice may also come from the ease with which members can be recognized as being unlike the rest of the population. The distinctiveness may be in physical or behavioral characteristics or in an unusual geographic or occupational concentration of group members.

Another way of classifying prejudices is by the type of reasons the prejudiced person gives for his hostility toward an outside group. Stereotypes (overgeneralized images) about these groups usually serve to justify the hostility. (Of course, if the stereotype were not just a stereotype, but a true picture of every group member, then the hostility might not be prejudice. This is hardly ever the case, though.) There seem to be two major kinds of stereotypes, each typically applied to only certain groups. One image depicts the inferior, unclean, contaminating group with which physical association is repugnant except in situations where social distance can be maintained. The other image involves the unfair competitor or dangerous subversive group, both threatening to take advantage of the unwary. The desire here is not so much for social distance as it is for keeping the objects of prejudice out of positions of potential power. Knowing the kinds of beliefs associated with prejudice toward a particular group helps us predict the way in which prejudice may be manifested against that group.

Is prejudice related to jealousy and other emotions?

The individual may experience several different emotions when thinking about or in contact with members of the group against which he is prejudiced. Jealousy is one of these emotions. When a group or some of its members are perceived as having material advantages or a high frequency of certain skills, or perhaps a lack of inhibition in behavior, the result of this perception (whether accurate or not) may well be jealousy and prejudice. In such cases the negative overgeneralizations about the group will take the form either of denial that the group's advantages are really desirable or of accusations of underhandedness in achieving these advantages.

Other emotions commonly found with prejudice are revulsion, fear, and hatred. Revulsion seems most typical as a reaction to groups who are considered inferior. Where there is prejudice of this sort, the individual will probably try to avoid any contacts with the group against whom he is prejudiced, lest he become contaminated. This fear of contamination is not the only kind of fear associated with prejudice. The person may also be afraid of being physically harmed, of competition with the outside group, and of being "outdone" by them. While this fear may be irrational, the emotion is real. Hatred would be most likely to occur in conjunction with prejudice when the targets actually challenge or resist prejudiced behavior or when the prejudiced individual feels he has been injured in some way by members of the target group.

One last emotion should be mentioned as sometimes associated with prejudice. This is guilt. When a person discriminates or otherwise harms an object of his prejudice, guilt feelings will often follow if his actions violate his normal code of ethics. A classic case study of this ambivalence over prejudice is *An American Dilemma* by Gunnar Myrdal of Sweden. His main thesis is that most Americans are torn between prejudice against Negroes and commitment to traditional American values that include equality of opportunity and justice for all. In this case and in many other instances of prejudice, guilt may arise, be recognized, and be suffered silently. Or it may be handled at the conscious level by projecting it onto the target of prejudice and making the latter to blame for its own injury. Sometimes projection of guilt may even follow injurious behavior that has not originated in prejudice, with the outcome that prejudice develops out of guilt rather than the reverse.

What are some of the harmful effects of prejudice?

We have just discussed some of the harmful effects on the prejudiced person. Such a person would be happier without feelings of jealousy, fear, and guilt. Additional harm occurs when he is prevented by his prejudice from entering into potentially rewarding associations with members of certain groups. But perhaps more important are the harmful effects of prejudice on the victims and on society at large.

Many of the effects on the victim of prejudice are obvious. If prejudice is shared by a dominant portion of society and is manifested in discrimination, the victim may not be able to get the job for which he is qualified or he may not be allowed to acquire qualifications his

abilities would permit. As a traveler, he may have to drive miles out of his way just to get a bite to eat. And he may be limited in his access to decent medical treatment and decent housing. If prejudice reaches the stage of violence, his very survival may be affected.

Not so obvious is the psychological damage that can be suffered by the victim of prejudice. Psychiatrists Abram Kardiner and Lionel Ovesey in 1951 and the psychologist Bertram Karon in 1960 reported, as one "mark of oppression" for Negroes, a frequent problem in the handling of aggressive impulses. It would seem that when persons are subjugated to overt expressions of prejudice against them, frustrations are bound to occur. Being in a defensive position, the victim cannot react freely against the source of his frustration. Instead, his anger is usually turned inward, undermining self-esteem, or directed against other members of scorned groups, his own included. Sometimes the anger is converted into efforts for self-improvement and self-advancement, the barriers of prejudice serving as a challenge. Occasionally the frustrations become so unbearable that the victim erupts into violence against members of the prejudiced group. Or the effort of suppressing this anger becomes so great that serious mental illness is the result.

The society's losses due to acts of prejudice can be measured from at least three standpoints. First, the cost of discrimination in terms of less-than-full utilization of manpower is a grave burden for a nation that values efficiency in production and where this efficiency requires that talent not be wasted for irrelevant reasons of race or creed.

Harm to society also comes when part of our basic ideology—the belief in justice and equality of opportunity for all—is not adhered to. Without the unifying force of common values, a society is hard put to maintain its strength.

And a third effect of prejudice on society can be seen in the damage it does to our position in international affairs. In most of the world—nearly everywhere outside of Europe—persons identify with our most victimized minority, the Negro. If there is disillusionment here concerning our devotion to the values of equality and justice, this is minor when compared with the loss of trust and friendship our country suffers abroad because of racial prejudice at home.

Are there any benefits derived from prejudice?

Yes, there are; and we would be remiss if we did not recognize this. It is hard to conceive of much benefit to society as a whole from prejudice, unless, perhaps, where its existence against an enemy in time

of war can be added to the rational cause of antagonism to further mobilize the populace. But there are definite advantages that can come to the prejudiced individual or group which help to explain the persistence of prejudice in a society trying to eradicate it. And occasionally, there are even benefits to members of the victimized group.

John Dollard of Yale, in *Caste and Class in a Southern Town*, cited three major types of gains the individual can derive from his prejudice. His discussion pertains directly to prejudice against Negroes, but also has application to other kinds of prejudice. He notes economic, sexual, and status benefits from prejudice. First, a prejudiced person may be able to gain economically when discrimination leaves the target of prejudice in a position ripe for exploitation. For example, the luxury (for some) of cheap labor in certain areas of the country is partly a product of employment discrimination against Negroes. This not only keeps Negro wages low, but also acts to depress the wages of others because the fear of potential Negro job competition puts all workers in a poor bargaining position with their employers. A person may also derive sexual gains from prejudice. This would occur, again, where discrimination permits exploitation. Third, prejudice may contribute to higher social status. As long as there are groups with other racial, religious, and nationality backgrounds available as convenient objects of prejudice and discrimination, persons in the preferred group can be assured that their status will remain above that of many others. Even among minority groups there is something of a "pecking order," with each having its share of prejudices against other groups, one motive being to designate some group lower on the status hierarchy.

We might add to Dollard's list of benefits the psychological ones that prejudice can give the individual when he can identify the cause of all his problems as some group of people. Also, as we shall note in a later section, the prejudiced person may gain from belonging to groups where prejudiced attitudes prevail and where all members are expected to share them.

Finally, we must mention that sometimes members of a target group can benefit from the prejudice. There are, for example, Negro professionals who are aided economically by their freedom from competition with whites in the market to serve Negroes. Being in a victimized minority also may sometimes permit license in behavior when such unrestrained behavior is looked for as "proof" that the victimized group deserves its lower status.

Is prejudice a mental health problem?

Sometimes it is, both from the standpoint of the prejudiced person and of the victim. Earlier we discussed some of the psychological problems that arise among persons who are the objects of prejudice. The chief difficulty seems to be with controlling the aggressive impulses that result from frustrations imposed by the group with prejudice.

We are indebted to several social scientists, Theodor Adorno and others (*The Authoritarian Personality*), for our best picture of the particular type of personality where prejudice seems most at home. The most distinctive features of the "authoritarian personality" are insecurity, rigidity in outlook, and intolerance of ambiguity. It is only the very rare case where these symptoms combine in full-fledged mental illness, such as paranoid fear of certain groups. But persons with "authoritarian" tendencies are generally not in the best state of mental health, because of their inability to cope with uncertainties and to treat situations in other than black-and-white terms. The "authoritarian" likes to see things as either "good" or "bad." There is almost bound to be prejudice involved in his ideas about who is "bad." In order to avoid ambiguity, he closes his eyes to the possibility of error in his initial judgment of groups and their individual members.

We must not permit the evidence from studies of the "authoritarian personality" to mislead us, however, into a view of prejudice as simply a manifestation of emotional illness or of tendencies in this direction. Many, if not most, people who display group prejudice can be considered quite normal otherwise.

What are the main causes of prejudice?

We have just mentioned one major cause—certain psychological problems that find a manner of solution in prejudice directed against an "outgroup." But the social psychologists M. Brewster Smith, Jerome S. Bruner, and Robert W. White, in *Opinions and Personality*, have identified this "externalization" of inner problems as just one source of attitudes toward others. A second source, "object appraisal," involves more or less rational evaluations of others and is not really a cause of prejudice, except where there is overgeneralization. But the third way attitudes are formed—through "social adjustment"—rivals, and may even surpass, "externalization" as the prime cause of group prejudice. By "social adjustment," we refer to the development of attitudes consonant with those of other persons with whom the in-

dividual has his closest contacts. One's own group of intimates is often the source of one's ideas about other groups. These attitudes are expressed in the group—be it family, close friends, or neighbors—and they are learned by newcomers into the group who have insufficient or no knowledge to counteract the opinions being circulated. Whether or not there is any initial inclination to reject these ideas, it becomes more or less a prerequisite for full membership in the group to espouse the prevailing attitudes. Thus, even those not predisposed to prejudice from personality or past experiences are likely to assume the group's attitudes just "to belong." In an interesting study, "Regional Differences in Anti-Negro Prejudice," *Journal of Abnormal and Social Psychology*, 1959, Thomas F. Pettigrew of Harvard demonstrates this point. He compared a group of Southerners with a group of Northerners and found no significant difference between the groups in their tendency toward authoritarianism. But he did find, as expected, great differences in attitudes about Negroes. Strong prejudice was standard among the Southern sample. It was the accepted type of attitude. This was not nearly so true among Northerners.

Does this mean that prejudice is often a product of one's environment?

Yes. In fact, if we go back far enough in the development of any prejudice, we can probably find something in the person's environment contributing to its genesis. It may be the prevailing attitudes of his parents, or later his friends, to which he has overgeneralized negative sentiments about a whole group which he associates with this experience. Or environment may contribute to prejudice in a less direct way—as when conditions affect the individual's personality so as to leave him more susceptible to prejudice.

How can prejudice be prevented or combated?

For those whose prejudice is the externalization of deep personality needs, one type of action is needed. This is different from the means best suited for combating prejudice that stems more from the situation in which the person finds himself.

In the first case, it will be necessary to prevent the expression of the individual's psychological needs from taking the form of prejudice. This may require a two-pronged attack: (1) working to overcome the psychological problems the person has, and, until this is accomplished, (2) providing less antisocial but equally self-satisfying outlets for externalizing these problems. Much of this kind of prejudice can be

eliminated by helping the person face his problems, and, at the same time, helping him to recognize the irrationality of his prejudice. In some cases, long periods of psychotherapy may be needed to accomplish these ends. The real difficulty here, of course, is in getting the prejudiced person to submit to this kind of treatment. Our society would not be interested in forcing such treatment—admittedly an infringement on freedom—except upon those who are most violent in their manifestations of prejudice.

When prejudice mainly serves the function of “social adjustment,” one possible method of attacking it would be to remove individuals from the group sharing the prejudice. The group might be dispersed and each member placed in a social environment where nonprejudiced attitudes prevail. But this is generally not a very feasible suggestion, even if it did not seem to violate personal rights. The only times when something approaches this type of change is when persons leave their homes and friends and go to college, the armed forces, or the like. These new environments may be “liberalizing” for the prejudiced individuals, but the changes of heart are not the result of direct coercion.

Education has been looked upon by some as the chief means for reducing all prejudice. Even those who have a deep psychological use for prejudice can usually be shown the irrationality involved, and all persons can receive training in American values of equality and justice, with specific application made to groups who typically are targets of prejudice. Such education is especially useful in breaking down some of the rationalizations for prejudiced behavior and in increasing the shame which prejudiced persons might have concerning their feelings. It is undoubtedly true today that relatively fewer people share the cruder stereotypes about minority groups. It is also true that public morality nowadays frowns on overt displays of prejudice—at least most of the time in most parts of the country. The rising level of education in our society has effected these changes.

But many social scientists now question the power of scholastic education to do more than alter the forms of prejudice. They do not reject the value of education in general, but feel that experience, rather than “book learning” or campaigns of persuasion, is the best teacher. They have research evidence to support this view. As a general rule, non-competitive, equal-status contact seems the most effective preventive or eradicator of prejudice—even when the initial contact is not voluntary, as with soldiers assigned to racially mixed combat groups (as seen in *The American Soldier*, a study by Samuel A. Stouffer and others), and

families assigned to integrated housing (described in *Interracial Housing*, a study by Morton Deutsch and Mary E. Collins).

Isn't it true that force cannot change the hearts of men?

This may indeed be true in the short run. But as we have just reported, persons' attitudes often do change gradually as a result of experience in situations not entered into voluntarily. Such situations, ideally, are those where members of the target group can be seen as the equals (but not competitors) of those who are prejudiced. Most situations of nondiscrimination would fit this description.

From society's standpoint, controlling the manifestations of prejudice (such as discrimination) would seem a more immediate need, anyway, than erasing prejudice from the "minds and hearts of men." Since achieving the first goal has a good likelihood of leading to the second, there is strong reason to recommend forceful action against discrimination—particularly in areas of public behavior—as the number one means of attacking the entire problem of prejudice in our society.

PREVENTION OF MENTAL DISORDERS

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Is there a need for preventive programs?

The large number of individuals suffering from various forms of mental disorder in the United States presents us with a problem that we cannot hope to solve with the treatment resources available to us. We shall never be able to recruit and train enough psychiatrists, psychologists, social workers, and nurses to treat adequately by traditional methods all those who request therapy. This difficulty is currently manifested by the long waiting lists at most community psychiatric clinics. As the stigma associated with mental disorder becomes reduced through programs of community education, and as the public gains greater insight into the nature of mental illness and the potential help to be derived from psychiatric treatment, the number of requests for therapy will increase, and will still further enlarge the gap between supply and demand.

Since the manpower pool from which mental health specialists are recruited cannot be enlarged much further, the only solution to this problem must lie either in a radical alteration of our approach to the treatment of established cases of mental disorder or in our programs to prevent their occurrence. This article deals with the latter approach.

What is the nature of prevention?

Viewed in this context, prevention is a community problem and not an individual matter. Programs for preventing mental disorders owe a great deal to the theories and methods that public health workers have developed for the prevention of organic illness over the last fifty years. Both in these programs and in the newer preventive mental health services, the focus is upon reducing the rate of sick persons in the community. This expresses itself in two different approaches, which are called *primary* prevention and *secondary* prevention.

Primary prevention is the name given to efforts to lower the "incidence" of new cases of disorder occurring in a population during a

certain period. The focus is upon altering those factors which influence the production of illness.

Secondary prevention has the goal of reducing the "prevalence" of established cases of a disorder at any particular time. This is accomplished not by the prevention of new cases but by reducing the duration of old cases. At any instant the rate of sick people in a population depends upon the number of both new and old cases, and the latter figure clearly depends upon the average length of the illness before recovery. In programs of secondary prevention, reduction of this figure is accomplished by early detection of cases and prompt, effective treatment.

What is the relation between knowledge of etiology and programs of prevention?

Some people think that in order to prevent an illness you must know what causes it. A knowledge of causation, or etiology, is certainly very useful. We know the causes of a number of mental disorders, particularly those associated with structural alterations in the brain, e.g., general paresis caused by syphilitic infection, pellagra psychosis caused by a vitamin deficiency, dementia caused by arteriosclerosis of the brain, the mental disorders caused by chronic alcoholism, the mental deficiency of endemic cretinism caused by iodine deficiency, mental disorders due to lead poisoning, etc. In some of these cases, this knowledge allows us to prevent the occurrence of the mental disorders by removing the causes before they produce their ill effects on mental health. Thus, pellagra has been prevented by ensuring an adequate vitamin-containing diet in the southern areas of the United States where it was once quite common; the incidence of general paresis has been dramatically reduced by the successful treatment of early syphilitic infection with antibiotics; mental disorders due to lead poisoning have been reduced by controlling the lead content of paints used on baby equipment and by protective measures for workers in lead industries; endemic cretinism has been prevented by putting iodide in the table salt in areas where it is missing in the drinking water, etc.

Unfortunately it is not always easy to make effective use of etiological knowledge in order to combat the causative factors and prevent illness. For instance, we know that the ingestion of a certain quantity of potassium bromide will usually lead to a toxic illness with psychotic symptoms. We have known this for years, but cases of bromide psychosis still occur regularly in our communities. True, the rate has

apparently decreased since many doctors have stopped prescribing bromides as sedatives now that they have better drugs available, such as barbiturates and tranquilizers. But bromides are freely available to the general public in proprietary medicines which can be bought at any drugstore without a prescription. The Food and Drug acts allow such medicines to contain only small quantities of bromide, but this drug is very slowly excreted and, therefore, can accumulate in the body until it reaches toxic proportions. The result is that a mental disorder of known etiology is not being prevented. An analysis of the reasons would involve a host of considerations ranging from the apathy of physicians to a lack of knowledge and interest of the general population, to the complications of the legislative process, and to the vested interests of manufacturers of proprietary medicines. The same point might be illustrated by examples from more general experience in the physical field, such as our lack of success in preventing traffic deaths due to speeding and alcohol intoxication, our inability to prevent heart disease associated with overeating, and to prevent lung cancer associated with cigarette smoking. True, our etiological knowledge in these cases is not as certain as in bromide psychosis, but even if it were, the problem of making use of it preventively would still not be simple.

When we turn our attention to the other side of the question and ask whether it is possible to prevent the many illnesses whose causation is not known, we find once more that the answer is not straightforward. The history of public health affords many examples of the effective prevention of illnesses at a time when their etiology was unknown. Scurvy in sailors was prevented by eating limes before it was known that the disease was caused by a vitamin deficiency; smallpox vaccination was introduced before the causative agent was known, and improvements in drinking water and sewage disposal prevented many infectious diseases before the germs that caused them had been isolated. Some of these programs were empirical, that is, based upon the effective exploitation of chance findings that certain measures seemed beneficial, but many of them were more scientifically based upon the observation that a population with a high rate of the disease differed in certain respects from a population with a lower rate of the disease. The difference often appeared related to certain aspects of the community's living situation—such as the nature of its food, water, or housing. The program of prevention then attempted to alter the environmental situation in order to correct the supposedly unhealthy influence. This was sometimes successful even though the nature of operation of this

influence was either unknown or was incorrectly explained. The use of personal isolation for the interruption of epidemics of infectious illness was originally based upon the theory that such illness was due to pestilential odors.

The prevention of mental disorders need not wait, therefore, until we know their exact etiology. This knowledge would undoubtedly be helpful, but there is plenty of progress to be made by capitalizing upon observations similar to those made by the pioneers in public health. Such observations have the aim of identifying pathogenic factors or situations which appear to be associated with an increased risk of contracting mental disorder in one population as compared with another in which the factors are absent. In this endeavor pure guesswork is likely to be wasteful, although an inspired guess based upon a chance empirical observation might be as valuable as the one that produced the lime diet to prevent scurvy among sailors. What is needed as a basis for a preventive program is a reasonable conceptual framework that is buttressed and progressively refined by clinical studies, and also by systematic epidemiological research consisting of careful comparisons of the characteristics of populations with differing rates of mental disorders or exposed to different environments. And since we must recognize the uncertain basis for most preventive programs, because of our current lack of scientifically tested knowledge of the causation of mental disorders, it is important that programs be constantly evaluated so that waste of money and effort be kept at a minimum by discarding those procedures which are found in practice to be ineffective. Of course, we must also press forward with basic research on etiology, with the expectation that additions to this knowledge will provide more secure foundations for our preventive programs.

Considerations such as these have, during the last five to ten years, governed the thinking of a number of pioneers in the field of preventing mental disorders, and some of their exploratory efforts will now be discussed.

Although these efforts will be described here as separate programs under the headings of "primary" and "secondary" prevention, it is to be emphasized that in practice they should optimally be coordinated and integrated within a comprehensive community program in which a systematic and planned attempt is made to appraise the range of local needs and problems, and to prevent, treat, control, and rehabilitate all types of mental disorder within a logical system of priorities consonant with the traditions and resources of the community.

What is the primary prevention program?

Programs of primary prevention have the goal of reducing the risk of mental disorder in a population by lessening harmful influences or by increasing the capacity of people to master such stresses in healthy ways. Mental disorders are conceived as resulting from unhealthy adjustment to burdens in the physical, psychological, or social spheres. Mental health, and its associated capacity for healthy adjustment to life's problems in ways which are consonant with the values and traditions of the prevailing culture, is thought to be based upon providing a person, throughout his life, with adequate physical, psychological, and social opportunities. If these are available at the appropriate times and in the right dosage, a person is likely to develop the psychological robustness of personality that will enable him to make optimal use of his inborn capacities and to be an effective and cooperative member of society, as well as being able to maintain his mental balance in the face of life's unexpected hazards.

An analogy with the field of nutrition is useful. Bodily growth and development depends upon a proper diet, and if this is qualitatively or quantitatively deficient, the person's physical well-being and his capacity to withstand many illnesses are impaired. The unhealthy outcome may be either a specific deficiency disease such as scurvy or rickets, or a more general increased vulnerability, e.g., to colds or to skin infections. A similar situation is thought to hold true in the psychological sphere. For example, the absence of a stable mother figure during a child's first two years of life may lead to a specific disorder of his personality, the so-called "affectionless character"—an emotionally cold person with limited capacity and need to relate to others, and a consequent disregard for the values of society as well as a poor capacity to control his own impulses—and in other individuals it may influence the development of a personality that is vulnerable to neurosis or psychosis.

In the same way that the science of nutrition teaches us what basic constituents are needed in the diet but does not attempt to prescribe the details of how they should be supplied (the exact form of menu and cooking, which will vary widely from culture to culture and according to individual taste), so the science of mental health must aim only at defining the fundamental personality needs, with the expectation that these will be satisfied in different ways from one culture to the next. For instance, it will be sufficient to ascertain that a small child needs to be cared for by a stable mother figure. In American culture this will

be the biological mother, in the Virgin Islands it may be the biological grandmother, and in an Israeli kibbutz the task may be shared between the biological mother and the child-care worker in the "baby house." We are, of course, still a long way behind the nutritionists in being able to specify with certitude the nature of the basic personality needs. The latter do, however, appear to be roughly classifiable into bodily needs and interpersonal relationship needs, and both of these are in turn affected by social factors—the values, structure, and traditions of society have a great influence upon the physical environment in which an individual lives, and upon the number and type of other people who relate to him, as well as the quality of their relationships.

Programs of primary prevention based upon these ideas focus upon influencing the life of people in a community so that basic personality needs are satisfied throughout life.

In the sphere of bodily needs this mainly involves ensuring the development of an adequately functioning brain and central nervous system—providing proper nutrition, protecting against physical damage by infection, poisoning, lack of oxygen, trauma, and exhaustion, and ensuring adequate stimulation. Hereditary influences upon brain functioning are currently being actively studied, and, in the future, eugenic programs may ensure that babies are born with better genetic endowment, or that couples who are likely to give birth to babies with inherited brain defects are advised against conception.

Preventive programs focusing upon physical factors include ensuring adequate prenatal care to pregnant women so that from conception onward the fetus will have adequate nutrition and will be spared harmful influences such as virus and other infections, poisoning by certain drugs, lack of oxygen, and physical traumata; influencing obstetric practices so that babies are born at full term without damage to the brain; protecting growing children and adults from poisons such as lead, and accidents such as head injuries; ensuring proper diet and appropriate opportunities for exercising their nerves and muscles especially in childhood and old age; providing adequate treatment for the physical illnesses which might attack the brain, such as syphilis, and pneumonia, etc.

In the psychological and interpersonal sphere primary prevention aims to ensure the satisfaction of a person's basic needs for interaction with others, for love and attention, for support in the face of difficult tasks, for freedom and independence in handling tasks within his capacity, for opportunities to gratify fundamental sexual and aggres-

sive needs coupled with help in controlling these drives in conformity with cultural prescriptions, for respect and status, and for membership in significant social groupings such as family, occupational, religious, political, and recreational groups, which define and teach him his life roles, provide him with appropriate models to copy, and help him develop and stabilize his own identity in relation to other people.

Preventive programs include family life education and marriage guidance to foster correct choice of partners and marital harmony; education of prospective parents so that they are emotionally prepared for the coming of their baby; prevention of parent-child separation in the first few years of life, and if this is unavoidable, provision of adequate substitute mother or father figures to lessen the burden of deprivation; supporting the integrity of the family, e.g., by the provision of homemaker services so that the family can stay together in their own home during periods of illness of the mother; ensuring healthy parent-child relationships by parent education and by guidance of parents in well-baby clinics, through school services, and through the intervention of pediatricians and family physicians; fostering an optimal psychological atmosphere in schools and at work so that individuals may feel secure in the knowledge that their needs and talents are recognized and respected; maintaining the social relationships and stimulating the social participation of older people, so that parents do not become deprived when their children marry and leave home, and so that the aging do not become isolated when their lifelong contacts are severed through death or change of residence, etc.

There remains the interesting question of social influence upon the satisfaction of physical and psychological needs of the citizens in a community. Many of the above examples of preventive work involve the personal interaction of professional workers with individuals, families, and institutions, but it is clear that the allocation of community resources for such purposes involves policy decisions at many levels of community administration. Those who are interested in primary prevention, both lay people and professionals, must therefore seek to influence governmental and administrative policies by social action and community education in order to ensure that policies, regulations, and practices take into account the mental health needs of the population. Such social action will be concerned with preventing deprivation and also with providing adequate community services to support the integrity of the family and to supply health promoting conditions in schools, industry, medical care facilities, social agencies, and recrea-

tional services. Stated this way, it may be considered so general as not to make much demand on the specialized interests or knowledge of preventive psychiatrists and their supporters. What such people add to those working for general community betterment is a specific focus upon the significance for mental health of a particular program or service, and this leads them to press for a higher priority for the provision of certain measures or the alteration of certain situations or practices than would otherwise be the case. For example, preventive psychiatrists may concentrate upon trying to alter the regulations governing introduction of bromides into proprietary medicines, or to influence the provision of homemaker services within the social agency structure of their community. Other community workers interested in general health and welfare betterment may not have realized the importance of these measures in reducing the risk of mental disorder.

In addition to these efforts which aim to reduce stress or to provide general community conditions favoring robust personality development, programs of primary prevention also focus upon providing services to help people facing inevitable crisis situations find a beneficial resolution of their current predicament. However healthy and mature a person may be, he will, from time to time, be involved in a life situation that upsets his usual mental equilibrium because it presents him with a challenge or a burden that is temporarily outside his current adaptive capacity, either because of its novelty or because of its magnitude. A crisis will result, which will eventually be resolved one way or another, possibly with important consequences for his mental health. The way the person adjusts during the crisis will be much influenced by the help or hindrance he receives from the significant people in his social orbit. This provides a most important opportunity for primary preventive intervention. (See *Emotional Crises; Marriage Counseling; Sex Education*)

What is the secondary prevention program?

The aim of such a program is to reduce the prevalence of the mentally ill in a community by shortening the duration of illness. As mentioned previously this is accomplished by gaining access to established cases, as early as possible, and cutting short their illness by effective treatment. In order to make a significant contribution to lowering community prevalence it is important to find methods of dealing in this way with large numbers of cases; therefore administrative and organizational problems are of considerable importance. It is essential

that screening and identification programs reach out into the community in order to gain access to cases which are not spontaneously recognized as mental illness by the sufferers or by their friends and relations. This is done through the intermediation of care-giving professionals, such as doctors, nurses, clergymen, teachers, etc., and by authority figures, such as executives and supervisors in industry. A good example is the detection of alcoholics which is being carried out very successfully in several industrial settings through the collaboration of industrial physicians and nurses with mental health specialists and with supervisors and management, all of whom are on the lookout for potential sufferers. The addition of screening for mental disorders to the multiphasic screening programs for physical illness in industrial settings, army induction centers, school systems, insurance plans, etc., is another useful approach to case finding.

A diagnostic service must also be organized, which will immediately deal with all identified cases. Any delay in arranging psychiatric investigation of possible cases will not only postpone treatment and prolong duration of illness, but will also lead to the loss of some potential patients, who have little motivation to involve themselves with psychiatrists when their current state of discomfort is relatively insignificant. An effective program of secondary prevention must develop ways of arousing and maintaining the motivation of potential patients to submit themselves for diagnosis and treatment, and also of educating the care-giving professionals so that they not only detect cases but ensure their attendance at the diagnostic clinic. Industrial programs for the control of alcoholism have been particularly successful in this, as a result of well-planned educational programs for supervisors and clear policy decisions by management.

Important for motivation and referral is the reduction of stigma traditionally associated with a mental disorder, and the arousal of hope that psychiatric treatment is likely to be helpful. Messages to achieve these goals can be conveyed by community education.

Programs of secondary prevention will, of course, only succeed if in fact psychiatric treatment is helpful. Idealists will say that treatment must not only be helpful but curative. But our concepts of "cure" in cases as vague as many mental disorders are questionable. Some psychiatrists will hardly ever admit that a patient suffering from a personality disorder has been "cured." They will nearly always be able to find unhealthy aspects in his thoughts and feelings. For that matter they would be able to identify some neurotic traits in all of us. In

practice, therefore, it is well to accept as the goal of such a program some operational definition of success, such as the disappearance of symptoms and the return of the patient to occupational and social competence. This may involve not only change in the patient, but also in his family and in his work situation; these may become more considerate of his needs.

If we accept this more relaxed definition of "success," which interestingly enough is commonplace in Europe but is not nearly as acceptable in the United States, where many psychiatrists seem to have the goal of absolute cure or basic reconstitution of their patients' personalities, psychiatry can certainly shorten the duration of many mental disorders. Even a condition as recalcitrant as alcoholism will yield to an appropriate program. Statistics in several industries show a "recovery rate" of 60 to 70 per cent for established alcoholics, which means that they have become well enough to return to normal working conditions and have stopped drinking. The issue is simpler with illnesses such as depressions, in which drugs or electroshock will produce satisfactory remissions within a few weeks in 80 to 90 per cent of cases.

One further feature characterizes a program of secondary prevention and differentiates it from many traditional psychiatric diagnosis and treatment facilities in the United States. The preventive service must keep abreast of the referred cases. Not only must there be no waiting list for admission to the diagnostic service, but also there must be no waiting list for treatment. This implies not just an adequate supply of professional staff, but efficient administrative procedures in the clinic or hospital, and a careful budgeting of staff time, as well as flexibility in deploying treatment resources to match current demands. Particularly important is the avoidance of stereotyped long-term treatments as a routine approach. Instead, there must be an attempt to use the least possible intervention which will help the patient find his way in life and aid others in his social orbit to support him in his trials. Therapeutic efforts are likely to be more effective if a case is treated soon after the onset of the illness; the earlier a case is seen, the shorter will be the treatment needed to resolve the problem. "A stitch in time saves nine" is a good motto for a program of secondary prevention.

It must be admitted that the requirement for an effective program of secondary prevention of mental disorders is rarely met at present in the United States. As with primary prevention, this is not due to a lack of knowledge about mental disorders, but to a lack of planning and to

our inability to overcome the organizational and administrative problems involved. The next few years should see much progress in this regard as well as improvements in our therapeutic armamentarium in the direction of shorter and more effective treatment methods for those mental disorders which still resist our efforts.

PSYCHIATRY

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What is psychiatry?

Psychiatry is the branch of medicine that studies, treats, and attempts to prevent mental and emotional illness. Its aims are threefold: to learn more about the causes and nature of emotional and psychological disorders, to treat them, and to improve mental health.

This definition can be elaborated in more detail. Psychiatry is a division of medicine that treats and studies disturbed thinking, feeling, and behavior. The difficulties may be in the "social" sphere, where an individual has marked difficulties in getting along with others as in extreme antagonism or unusual or continued aggressiveness or assaultiveness, whether verbal or physical; in disturbed "feelings" such as extreme distrust, suspicion or fear, feelings of being discriminated against or persecuted, or in withdrawal, unwillingness or inability to collaborate, and persistent worry and depression or the opposite such as undue feelings of elation with restlessness and abnormal excitation; in "medical" areas such as in pains of an emotional origin, pains of unusual intensity or persistence; or in excessive distortions of "thinking" such as delusions and hallucinations. There is thus a broad spectrum, from ineffectiveness and dissatisfaction or unhappiness in one's relationships (neurosis) to marked disabilities, incapacities, and distortions (psychoses).

What are the functions of psychiatry?

Psychiatry has several functions. The most urgent of these functions is the care and treatment of psychiatric patients, both those who must be treated in mental hospitals or increasingly in general hospitals, and those who can be treated as outpatients or in private offices. Much

of the treatment of psychiatric patients today is carried on by highly trained people who are not psychiatrists, such as psychologists, social workers, counselors, clergymen, nurses, aides, attendants, and even volunteers. An important function of psychiatry is to train, organize, and supervise the work of such personnel.

There is much to learn about the causes, nature, and treatment of psychiatric illnesses. A great deal of investigative and research work is being done to increase knowledge and improve methods of treatment. Thus another major function of psychiatry is to conduct and participate in research and experimental work.

Although there is much to learn, a great deal is already known. A third function of psychiatry is to teach what is known. Since so many different kinds of training are involved in psychiatric treatment and research, psychiatry must teach many different groups of people: medical students who will become physicians, graduate physicians who are specializing in psychiatry, graduate physicians who are specializing in other fields of medicine or who are involved in general practice, psychologists, social workers, nurses, aides, attendants, occupational therapists, recreational directors, teachers, school and college counselors, vocational guidance personnel, labor and industrial counselors, marriage and family counselors, probation officers, ministers, and many other groups who are concerned with human behavior. A most important activity is to help relatives of patients, to educate and inform people that much emotional and mental illness is preventable in its early stages, especially when people are under unusual stresses and strains; that these conditions are treatable and curable with adequate resources and that they are not mysterious, not an evidence of character weakness; that the patients are not to be stigmatized, ashamed of, isolated, and punished, but are to be understood and helped by the establishment of secure and constructive relationships with people experienced in guiding patients with such disorders back to health, normal function, and social relationships.

How does psychiatry differ from psychology and psychoanalysis?

Psychiatry differs from psychology in two major aspects. Psychiatry is a branch of medicine; psychiatrists must have graduated from medical school and in addition must have received specialized postgraduate education, usually for a minimum of three years after completing medical school. Psychology is not a branch of medicine; very

few psychologists have received a medical education and hence cannot treat patients medically. A psychologist is limited to nonmedical treatment; a psychiatrist is trained to give both medical and psychological treatment.

Psychoanalysis has three aspects. It is a method of treatment, a method of research and investigation, and a body of knowledge. As a method of treatment, it is one of several different kinds of psychological treatment. In the United States, the great majority of those persons using psychoanalysis as a form of treatment have also received medical and general psychiatric training. In other countries, many psychoanalysts are not physicians and have not been trained in general psychiatry. Psychoanalysis is a collection of observations, data, theories, and types of treatment, used both by students of human behavior and practitioners as a basis and guide for their procedures. As a method of research it is used not only by psychiatrists but also by nonmedically trained people who are interested in human behavior, such as psychologists, physiologists, sociologists, and anthropologists. (See *Psychology*; *Psychoanalysis*)

What are the various "schools" of psychiatric thought?

The first major category of psychiatric theory and practice consists of the "organic" schools. This group believes that the major advances and understanding of the nature of mental illness and its treatment will come through further investigation of the physical makeup of man. It is chiefly concentrated on biochemical (and the chemical basis of heredity), neurophysiological, metabolic, anatomical, and neurohormonal lines. Therapy consists of guidance, direction, the use of drugs, or physical-chemical methods of treatment such as electric shock and insulin coma therapy.

The second major category comprises the "psychological" schools, including the various schools of psychoanalysis. The latter has two chief divisions: one which concentrates on the inner life and inner conflicts of patients as in classical psychoanalysis; the other which emphasizes the environmental aspects of cultural conflicts and social or environmental strains in the causation of disturbed functions. There are also the nonanalytic psychotherapists, behaviorists, motivationists, learning theory proponents, attitudinal or relationship therapists, and environmentalists.

The lines of difference between these various groups are more sharply

drawn in research and theory than in the practice of psychiatry with actual patients.

Another major category includes the "eclectic" schools, which are not committed to a single theory or line of thinking, but attempt to combine whatever is useful and fruitful in theory, research, and practice from the various schools.

There are approximately 12,000 psychiatrists in the United States, including more than 1,000 psychoanalysts and probably a similar number in psychoanalytic training.

What is the eclectic approach?

Eclecticism chooses thoughts, suggestions, and procedures of therapy from diverse systems of thought in the formation of theories, hypotheses, and practices that seem appropriate and effective. Perhaps a better term than eclecticism would be comprehensive psychiatry, implying and ensuring critical purviews of patients and their conditions from the biological, chemical, medical, neurological, psychological, social, environmental, and cultural points of view.

Eugene Ziskind in his book, *Psychophysiologic Medicine*, describes this approach very well: "The eclectic point of view takes its origin from the opinion, held by many if not most psychiatrists, that the state of the knowledge of mind is as yet too inadequate to warrant a 'system.' To them, factual knowledge is quite fragmentary; therefore the most effective and practical procedure is to accept and evaluate concepts on the basis of evidence without adherence to any of the overall postulates or procedures proposed by some current systematized schools."

How does the practice of psychiatry differ in various countries?

In many countries of the world the practice of psychiatry is little developed. It is most highly developed in Western Europe, Canada, and the United States. Despite the large number of persons afflicted with psychiatric disorders, the practice of psychiatry is usually given a relatively low priority among the medical specialties in countries that are relatively undeveloped scientifically, educationally, and technically.

Russian psychiatry is chiefly along Pavlovian and anatomical-biochemical lines. It is authoritative, optimistic, environmental, and socially redemptive. Conditioning or processing by experience is thought to be the main cause of emotional or mental illness. New conditioning, new social experiences with one's fellows are processes of therapy. Ger-

man psychiatry is strongly influenced by organic schools of thought. In France psychiatry is more critical and eclectic. In England especially, and in the Scandinavian countries, psychiatry has been more highly developed in their public services (both hospital and community-wise) than in the United States. Canada, Australia, and New Zealand tend to be more eclectic in their approach to psychiatry.

A new trend has appeared in German, French, and Swiss psychiatry, namely existentialism. Existentialism in psychiatry and psychoanalysis is derived from many sources, chiefly philosophical. It is a point of view rather than a technique. It emphasizes the normality of anxiety in the conduct of life, and the threats of meaninglessness and of nonbeing. Other emphases are that living is more important than thinking, practice more important than theory, and man as a process of "becoming" is more important than man as static and as a product. The artificiality of the separation of man into object and subject is stressed. If one person fails to relate to another, distance is maintained and he treats the other as an object. The relationship becomes "I-it" instead of "I-thou." The therapist seeks to enter into the patient's being and to experience his world. (See *Existential Therapy*)

In hospitals and clinics in the United States (with the exception of private practice with adult patients), a "team" approach is quite characteristic in treatment. The psychiatric treatment team consists of a psychiatrist, a psychologist, and a social worker, all of whom participate in and contribute to the patient's treatment. In the United States, psychiatry has emphasized the team approach, group therapy, psychosomatic medicine, child guidance, mental hygiene, and psychoanalysis.

With the introduction of the newer drugs, both the tranquilizers and the psychological energizers, American psychiatry has become much interested in psychopharmacology and in the chemistry of mental and emotional illness. The physiologist, Walter Cannon, studied the physiological and chemical correlates of the emotions of fear, pain, rage, and hunger. In the early part of the century Cannon thus laid the foundation for much of the later development of psychosomatic medicine. Cannon studied acute stress, whereas Hans Selye studied chronic stress and the hypothalamic-pituitary and adrenocortical axis. Pavlov in Russia studied the disorganizing effects on the nervous system of prolonged, irritating, or disturbing stimuli. Sigmund Freud, of course, studied and emphasized the psychological and emotional effects of unwholesome and injurious relationships with the parents in early life. (See *Psychopharmacology*)

Do the divergent schools of psychiatric thought affect psychiatry's goals or its acceptance by the layman and the medical profession?

The general goals of all types of psychiatric treatment are the same: to cure the patient or help him become as well as possible. How to get the patient well differs, sometimes quite markedly, with the different schools of thought. Also, there are some lesser differences of opinion among the various schools as to what constitutes a cure.

In a study by August Hollingshead and Frederick Redlich of Yale University, it has been found that different classes of people in the United States have quite different ideas as to what psychiatric treatment is, and these different expectations rather markedly affect their acceptance of the different kinds of treatment. For example, some persons think of psychiatric therapy in terms of psychoanalysis or some other type of intensive psychotherapy, whereas others expect to be given medicine or another kind of physical treatment and do not accept psychotherapy very readily. In general, patients with more education and from the higher income brackets ask for and demand intensive psychotherapy or psychoanalysis. Conversely, those with lesser education and from the lower income brackets ask for and receive more drugs and physical methods of treatment.

Similar variations in preference for, or acceptance of, different kinds of psychiatric treatment also apply to physicians in general practice and to psychiatrists. The greatest differences in the acceptance of the different schools of psychiatric thought among psychiatrists themselves are found between members of the psychiatric profession in different countries. Psychoanalysis is much more extensively practiced in the United States than in England, France, Germany, or Russia (where psychoanalysis—being the highest degree of concentration on the individual in treatment—is not used). The influence of psychoanalysis in the United States is very great. However, classical and rigid psychoanalysis is tending to be much less rigid and dogmatic as experience and practice is extended.

Is psychiatry a science?

There are many definitions of "science," varying from the exact mathematically predictive sciences to social and political sciences at the other end of the scale. Psychiatry is not an exact, mathematically predictive science. However, it is a science in the sense of an organized body of observations, theories, and procedures; and it is predictive to a certain extent. The scientific method is used increasingly in psychiatric

research. Fewer and fewer psychiatric reports consist of case histories and mere clinical observations on a class of cases. Improved methods of measurement and observations are continually being developed in psychiatry; such methods are an important cornerstone of any science.

Psychiatric research is more scientific than psychiatric practice. Even as numbers and mathematical processes can be used in an unscientific way, so at times is psychiatric knowledge used in an unscientific way. Many of the phenomena that are observed in psychiatry await a scientific explanation. The lack of specific knowledge with regard to causation, the multifactored etiology, the diversity of theories, the multidisciplinary effectiveness in therapy, all contribute to the lack of specificity, definiteness, and rigorous correlations found in the more exact physical and biological sciences.

What is the history of psychiatry?

The description and recognition of psychiatric illnesses as separate disease entities amenable to psychological forms of treatment go back as far as early Greek medicine. However, in Europe for the first eighteen centuries of the Christian Era, mental disorders were not considered to be diseases but were thought by most people to be the result of magical or supernatural causes. They carried great moral and religious connotations. Punitive procedures and concepts were predominant.

In the latter half of the eighteenth century, largely as the result of efforts by such persons as Philippe Pinel in France and William Tuke in England, mental disorders gradually began to be considered a branch of medicine and an object of study by physicians and scientists. These great men removed the chains from mental patients, and the humanitarian era of treatment began. Psychiatry and neurology were very closely associated through most of the nineteenth century, and attempts were made to understand mental illness largely on the basis of structural damage to the central nervous system. Treatment was largely restricted to major mental illness requiring hospitalization. (See *Neurology*)

In the latter half of the nineteenth century Jean Martin Charcot's demonstration in Paris that the symptoms of major hysteria could be caused by "ideas" was investigated by Hippolyte Bernheim, Ambroise Liebeault, and Pierre Janet, and in great detail by Freud. Freud became convinced that unconscious feelings and ideas played a major role in the causation of many types of mental illness. Emil Kraepelin in

Germany had supplied detailed descriptions of different types of mental illness that still remain the basis for the classification of psychiatric disease.

During the first half of the twentieth century there was much work done in attempting to explain the causes of mental illness on psychological lines, chiefly as a result of the work of Freud. Some of the leaders in this work were Eugen Bleuler, Carl Jung, Alfred Adler, Otto Rank, Karl Abraham, Sandor Ferenczi, Franz Alexander, Sandor Rado, and Karen Horney. In the United States, Harry S. Sullivan did important studies on the social relationships of patients and emphasized interpersonal relations in the causation and treatment of many emotional and mental illnesses. Bleuler, in using the word schizophrenia, took hopelessness out of the old term *dementia praecox*, and in his studies, based partly on psychoanalytic foundations, extended greatly the understanding of schizophrenia. Ernst Kretschmer studied relationships between body-build and various types of mental illness. In the United States, there has also been a continuous development of psychiatry since the days of Benjamin Rush. The American Psychiatric Association, founded in 1844, is one of the oldest national medical specialty groups in the United States. American psychiatry has been strongly influenced by European psychiatry. Freudian ideas and methods were quickly received and developed in the United States after 1910; and many of the psychiatric leaders in the United States, A. A. Brill, William A. White, S. E. Jelliffe, were greatly influenced by Freud. At the same time that Freud was developing his theories, Adolf Meyer, who came from Switzerland, was working out his concepts of psychobiology at Johns Hopkins in Baltimore. He emphasized the importance of life experiences interacting with biological factors in the development of mental illness. He was the leader of American psychiatry.

During and after World War I the psychological and sociological factors in psychiatry were recognized as of major importance (Thomas Salmon, Earl Bond, Edward Strecker).

Insulin coma therapy, electroshock, brain surgery, and the tranquilizers were first developed in Europe.

America takes credit for originating group psychotherapy and the team approach, child guidance clinics, psychosomatic medicine, and the great expansion of psychoanalysis. Cultural, sociological, and anthropological aspects of psychiatry were developed in the United States by such persons as Harry Stack Sullivan, Karen Horney, Erich Fromm, and Margaret Mead. Important early studies in psychosomatic medi-

cine were made by Franz Alexander and Flanders Dunbar, among others. The work of William H. Sheldon in body-build, Franz Kallmann in genetics, W. Horsley Gantt in Pavlovian conditioning, and other experimental workers has been most significant.

At the present time in the United States great efforts are being made to expand research activities of many different types, and to train non-medical personnel to make psychotherapeutic techniques available to the large number of people who are in need of such services. In addition there is great effort being made, partly as a result of a study by the Joint Commission on Mental Illness and Health, to expand the mental health resources of the country, to bring psychiatry into the community, and to make psychiatry's special methods of treatment available in general hospitals, clinics, and general practice. The crusading work of Clifford Beers (a recovered mental hospital patient), Adolf Meyer, and other foresighted physicians and citizens, together with the impetus for melioration that came from Dorothea Lynde Dix, and the tremendous push of optimism for the treatment coming from psychoanalysis, formed the bases of the mental hygiene movement in this country—the National Association for Mental Health (formerly the National Committee), the founding of the National Institute of Mental Health, and the formation of the National Committee Against Mental Illness. Mental health societies throughout the country, departments of psychiatry in medical schools, and public mental hospitals are making great efforts to meet the challenge of mental illness in this country. Karl and William Menninger have educated people throughout the United States in matters of psychiatry and public responsibility for mental health.

Has the field of psychiatry changed its goals or methods since Freud formulated its first concepts?

Freud's original therapeutic goals were quite limited in that he believed that psychoanalysis as a form of therapy could only be used in a limited number of neurotic illnesses, such as hysteria, phobias, and the obsessional states, occurring in particular types of patients. However, his expectations as to the results of psychoanalysis in teaching us about human behavior in such diverse fields as art, literature, religion, society, the behavior of nations, and the severely mentally ill, were profound and far-reaching.

During his own lifetime, Freud changed his views and expanded his goals tremendously. Today psychoanalysis as a method of treatment is used with a far wider variety of patients than Freud originally antici-

pated. Some psychiatrists are still carrying out psychoanalysis along the lines prescribed by Freud. In many places, however, modifications of psychoanalytic techniques are being used (Alexander, Horney, Rado, Sullivan), and the knowledge of human behavior gained through psychoanalysis is being applied in other forms of psychological treatment as well as in the strictly psychoanalytical.

Many forms of behavior now considered to be evidence of sickness and potentially treatable were not even considered to be psychiatric illnesses a few decades ago. Alcoholism, delinquency, marital problems, and many difficulties in vocational and social adjustment fall into this category because, chiefly through the work of Freud, one can, in many instances, now recognize such behavior as a symptom of neurotic or emotional conflict.

What is the medical profession's attitude toward psychiatry?

There are now more than 250,000 practicing physicians in the United States. As would be expected in such a large group, individual attitudes vary tremendously, from uncritical acceptance to an extreme degree of skepticism that insists that psychiatry is not medicine, but rather mysticism, intuition, and pretense. A very small number of psychiatrists would like to set up schools apart from schools of medicine to train psychiatrists in psychological or psychoanalytic methods of treatment and research. They believe in this because of the supreme importance they attach to psychological processes in causation and treatment.

For many years, until World War I, the practice of psychiatry was almost entirely limited to hospitalized patients. The vast majority of such patients were treated in separate, specialized psychiatric hospitals, which tended to isolate psychiatrists from the rest of the medical profession. In World War I, shell shock—of which there were a great many cases—proved to be a disturbance in the psychophysiology of the patients rather than in their body systems. Between World War I and World War II, the interest of psychiatrists was directed toward greater psychological understanding of patients and explorations of various psychological techniques of treatment. This, however, continued to maintain the isolation of psychiatry from traditional medicine.

Since World War II, there has been increasingly official acceptance of psychiatry by physicians in general, as a result of the beneficial effects of psychological management and treatment of soldiers and patients, and also in consequence of the great development of psy-

chosomatic medicine. Increasing acceptance has been shown by the growth of psychiatric teaching in medical schools, the increasing number of psychiatric patients being treated in general hospitals, the inclusion of psychiatrists in group practice, and increased support of psychiatric training and research by public funds.

Psychiatry is recognized as a specialty branch of medicine by the American Medical Association. Specific requirements as to training, experience, and examination have been set up, leading to a certificate in psychiatry by the American Board of Psychiatry and Neurology. (See *Psychosomatic Illness*)

What effect has psychiatry had on present-day living?

The development of dynamic psychiatry in the twentieth century has had a tremendous impact on many aspects of society. Some of its effect has been indirect and is difficult to evaluate precisely. In several areas its impact has been more direct and the effects are more obvious. Alfred Adler, one of Freud's early associates in Vienna, was one of the first to apply dynamic principles to society in the field of education. Because of his emphasis on strivings for power as compensations for inferiority, as opposed to Freud's emphasis on sex as a primary motivation, Adler soon broke away from Freud. As a result, one now recognizes the importance of motivation, anxiety, the dynamics of home life, the personality of the teacher, and unconscious or experientially originated psychological processes in the learning of normal people as well as in neurotic patients. This knowledge has led to much experiment and change in the curriculum, methods of teaching, and the preparation of teachers in the educational system. Many schools now have psychiatric consultants and counselors available. Special schools have been established to teach children who, for psychological reasons, are unable to learn satisfactorily in the usual school setting.

Psychiatry's effects on industry are shown in methods of selection of personnel, patterns of management, and the recognition of the effect of psychological factors on production rates and the occurrence of accidents. There are many thousands of foremen who receive training in "listening to" and counseling employees who are upset, dissatisfied, have grievances, have accidents, or are doing poor work. Dynamic psychiatric principles have also been applied to selling and advertising. There is now a recognized psychiatric subspecialty called industrial psychiatry. (See *Work and Mental Health*)

Psychiatry's influence on family life has been tremendous, but is

perhaps difficult to assess. Certainly there has been a profound effect on practices of child rearing, attitudes toward childbirth, weaning, and modification of parental attitudes toward discipline, in the direction of less authoritarianism, more permissiveness, and more realistic goals for children. Attitudes toward childhood sexuality and expectations of childhood behavior have also changed. Families reflect these changing attitudes in various ways. In general, there is greater tolerance of children's behavior, a more realistic expectation of their capabilities at different stages in their growth, and a greater recognition of the child as a separate personality with certain rights, needs, responsibilities, and worth. (See *Child Development; Psychosexual Development in Man; Parenthood and Child Rearing*)

Changes in family life have paralleled changes in social life. Victorian attitudes about human biological functioning and the place of women in society have been radically altered. More of an attempt is made to understand the motivations behind behavior, and less significance is attached to judging the individual or the group on the basis of behavior alone. Certain types of behavior are now legally recognized as being evidences of illness rather than as just criminal action, and are beginning to be handled by society accordingly. In addition to the legal profession, literature and political science show many examples of society's concern with inner motivations—whether in concepts of responsibility for crime and murder (the Durham decision), sexual deviations (new laws in California and the District of Columbia), or efforts to help drug addicts (at the United States Public Health Service Hospital at Lexington, Kentucky), or to help the “rebel.” (See *Motivation; Crime and Mental Disorders; Durham Decision; Sexual Deviation; Alcoholism; Narcotic Addiction*)

Concepts and practices of religion have changed greatly. Many priests, rabbis, and ministers spend a significant proportion of their time in counseling, for which many of them have received specific training either in seminary or postgraduate courses. Sermons and religious writing reflect interest in depth psychology and existentialism. Some of the established Protestant denominations have shown a swing away from puritanism and Calvinism, which is in part the result of increased understanding of the dynamics of behavior and the harm of excessive requirements and fanaticism in religious and social life.

Earl A. Loomis, Jr., in *The Self in Pilgrimage*, describes in clear and telling terms, with examples, the psychological evolution of the individual from primitive concepts of religion and justice to a more

effective, optimistic, realistic religion, based on the newer psychological and psychoanalytic understanding and control of the primitive in himself and society. (See *Pastoral Counseling; Religion and Psychiatry*)

What contributions has psychiatry made to medicine?

Psychiatry's contributions to medicine have not been limited to the field of psychiatric illness alone. There is a growing tendency in medicine to consider the patient as a whole—with feelings, needs, and attitudes—not just as an example of a particular disease or a collection of parts that operate independently of each other. As a result, the doctor-patient relationship is undergoing profound and beneficial changes and is being studied intensively from many angles.

Psychiatry is being recognized as one of the great tools of therapy, whether in a patient with anxiety, gastric ulcers, colitis, a skin condition, or in the various kinds of counseling. Much more time is spent in courses in psychiatry, and the psychological approach to the patient is being emphasized in other branches of medicine. Postgraduate courses in the psychological approach to the patient are being given to those physicians who completed their medical education before the changes in medical school curricula were instituted. Several medical schools now include psychoanalytic institutes, and psychiatry is becoming an increasingly important medical specialty. But the specialty, except for research and teaching, is probably the least important aspect of psychiatry. It is psychiatry in the general practitioner's office, in surgical and medical wards, in the home, in marriage, in school, in church, in recreation, that is the most important aspect. Patience, considerateness, tolerance, listening, search for understanding, the healing effect of interest, the relief from talking things out, saying frankly what is on one's mind, the resources that develop from searching together for solutions, the recognition of feelings and needs, the giving of respect, security, dignity, worth, and "identity" to patients—these are contributions of inestimable value that psychiatry has given to medicine and that are great helps even in the healing of physical troubles. (See *Psychotherapy*)

What has psychiatry contributed to other fields, such as philosophy and literature?

A more profound understanding of the nature of man and his relation to the world through an appreciation of the dynamic psychological forces at work in the individual has been one of psy-

chiatry's greatest contributions. The same laws that apply to the physical world also apply to the psychological world; in fact, the two are parts of the same whole. The theory of the unconscious has profoundly influenced philosophical concepts of man and the understanding of not only the unusual individuals who represent genius and great artistic production, but also the behavior and difficulties of the normal person, as well as the neurotic; excesses of achievement or aberrancy, difficulties, disturbances, distress, problems, stresses, challenges, aspirations, become more understandable and manageable as contexts and processes than they used to be. There is much that is disappointing, hard, brutal, and realistic; but the newer psychiatry, psychoanalysis, and psychology give us a foothold from which to move into conditions that were formerly thought to be hopeless, predetermined, or theological, that is, outside of man's concern and competency. (See *Genius; Creativity*)

Man's relation to himself and to other men has become a major area for philosophic interest, partly as a result of this psychological revolution. A great deal of current literature emphasizes a concern with the unconscious processes; this is also shown in drama (including movies and television) as well as in painting and sculpture. Forward-looking politicians and government leaders are consulting advisers and experts not only in political problems and manipulations, but in social relations, international reactions, and "ultimate concerns" (Paul Tillich). (See *Politics and Mental Health*)

Lev Tolstoi, Fëdor Dostoevski, D. H. Lawrence, Walt Whitman, Ralph Waldo Emerson, Henry Thoreau, Sigmund Freud, Reinhold Niebuhr, Paul Tillich, Albert Schweitzer, and Mohandas K. Gandhi—make the whole world kin. We may be more discomforted and discouraged, but we are less alienated and disconnected (A. N. Whitehead) from the course of things and reality. All this represents challenge and opportunity. (See *The Unconscious; Neuroses; Neurosis and Normality*)

Has psychiatry's prestige been increasing?

Yes. With increased knowledge about emotional illness and increasing ability to help those who are mentally ill, psychiatry's prestige has increased both with the medical profession and with the general public, perhaps more with the latter than with the former. With the greater respect accorded to the profession, increasing numbers of

people, well trained and worthy of respect, have been attracted to it; this in turn has increased its prestige.

Psychiatrists are now accepted not only on the faculties of medical schools, but also in schools of law and theology; their help is asked for by courts and schools. These are signs of increased acceptance, competence, efficacy, and prestige. The psychiatrist is no longer thought of as a "mental alienist" working in some isolated hospital for the insane. Part of this increased prestige is due to a greater understanding that mental disorder is an illness and should carry no stigma. The feelings of shame and the connotations of sin and wrongdoing formerly connected with mental illness in the public mind have greatly diminished, thereby dignifying the position of those who treat sufferers from these illnesses.

An increasing recognition of the size of the problem of mental illness, its frequency, and how common it is in the community, have made people aware of the importance of the profession attempting to deal with it. Mental disturbance and illness are not signs of character weakness. Great men have been mentally ill at certain times in their lives; the list includes Abraham Lincoln, Thomas Jefferson, Charles Darwin, and Isaac Newton. Being mentally ill once does not mean being mentally ill always. Mental illness in one aspect or in certain aspects of one's mind does not mean mental illness in all aspects of one's mind. Creativity is possible with great illness and suffering, whether of mind or of body.

How should an individual select a psychiatrist?

An individual should begin by asking the advice of his family doctor, company physician, teacher, college physician, or his clergyman. If an individual is in a situation where none of these is available, he may go to the clinic of a hospital or a mental health center and discuss his problems there. The discussion will most likely be with a social worker who is trained to give such advice, or with a family agency.

A president or secretary of a county medical association can be helpful in guiding a patient toward psychiatric treatment. The health director of a city or the president of the medical board of a hospital can be of help. A visiting nurse, a public health nurse, or the doctor of a large industrial plant can guide one to the available psychiatric facilities.

Most of these sources will give some information about the back-

ground and experience of the psychiatrists, and some general information about the cost of treatment. More specific information about the cost should be asked for during the early visits to the psychiatrist or clinic. (See *Agencies*)

What is the average consultation fee?

Rates for consulting a private psychiatrist vary in different parts of the country and in different communities. Many psychiatrists, as do many physicians, conduct consultations and treatment for a low fee or on a free basis for needy patients. Even psychoanalytic institutes offer services of psychiatrists, who are in psychoanalytic training, for a very low fee. Clinic fees are usually determined by the social worker at the time the decision is made to begin treatment. These fees are usually dependent upon the individual's income and resources, his financial obligations, and the policy of the clinic. They usually run from a dollar a visit up to fifteen dollars a visit.

How many psychiatrists are there in the United States?

There are more than 10,000 members of the American Psychiatric Association, most of whom are in the United States. Not all of these are engaged exclusively in the practice of psychiatry; some have retired from practice, and many are full-time employees in government and university work, or in state hospitals. An unknown number, probably relatively small, of qualified practicing psychiatrists are not members of the American Psychiatric Association.

Figures from other countries as to the number of psychiatrists are difficult to obtain. In many countries there is no national organization such as the American Psychiatric Association, and in some, psychiatry is not considered a separate specialty in medicine. It seems certain that there are more active psychiatrists in the United States than in any other major country, both with respect to the total number and in relation to the population. The chief reasons for this difference are economic and cultural. Psychiatry is usually one of the last specialties to be developed; surgical and medical specialties usually precede psychiatry in their growth. Only a sound economy can support psychiatry adequately, or the resources of a state extensively devoted to the medical and psychological welfare of its citizens. India, with a population several times larger than that of the United States, has probably less than several hundred psychiatrists.

What qualifications are necessary to become a psychiatrist?

The first essential qualification is graduation from an approved medical school. Legally, any physician who has a license to practice medicine may practice psychiatry and call himself a psychiatrist. However, there are certain other requirements that must be met before a physician is considered, by his colleagues, to be a psychiatrist. In order to obtain a certificate as a specialist in psychiatry from the American Board of Psychiatry and Neurology, an individual must have completed three years of approved specialized training in psychiatry and, in addition, must have had at least two years of practice in the field. He is then entitled to take the national examination and, if he is successful in the examination, he will then be granted a certificate.

To effectively practice psychiatry, an individual should be relatively mature, emotionally stable, objective, and, for the most part, non-judgmental. He should be free of any major mental illness. It is of great help to the psychiatrist, particularly if he is using much psychotherapy, to have a broad knowledge of the social class from which the majority of his patients come. The psychiatrist must be quite secure and comparatively free from anxiety. Some psychiatric training centers require psychological examination and testing before candidates are accepted for psychiatric training.

Where are psychiatrists employed?

Psychiatrists are employed either full time, part time, or as consultants in many different places: hospitals, including public mental hospitals, which probably employ a quarter of the psychiatrists, and governmental, community, and private hospitals; industry, both by labor and management; school systems, medical schools, other graduate schools, such as nursing, social work, law, and theology; courts and prison systems; community health agencies; and group private practice.

Do most psychiatrists have their own private practice?

Most psychiatrists do some private practice. Due to the large number of patients treated in state and federal psychiatric hospitals, more psychiatrists are employed by hospitals than in any other clinical speciality in medicine. The conditions of such employment prevent many of these psychiatrists from doing private practice.

A great many psychiatrists do not "give time" to clinics because most clinics are supported by community, state, or federal appropriations,

and the personnel are mostly on full-time salaries. A great many psychiatrists give time to teaching, which includes supervision of the treatment given clinic patients. In those communities where there are no medical training centers, many psychiatrists give time to clinics.

What is the average income of psychiatrists?

A large number of psychiatrists do only a limited amount of private practice; the average income for this group is much lower than for the group that devotes most of its time to private practice. The average income for psychiatrists in the United States is slightly under \$17,000.00, which places psychiatry in the bottom half of medical specialties with regard to average income.

Is psychiatry's new emphasis on drug research a prediction of things to come in the search for the workings of the mind?

A great deal of work will continue to be done with drugs in two directions: toward more effective treatment and toward increased understanding of the workings of the patient's mind. In research today a number of drugs are used that tell a great deal about the way the mind works, although they do not cure the patient.

At the same time, there is an increasing emphasis in other areas of research, particularly psychology, sociology, and biochemistry, which are giving great promise in the search for the understanding of the mind.

The use of drugs in treatment reduces anxiety, tension, resentment, distrust, or aggression, so that a patient's realistic perceptions, interpretations, and control can establish themselves and become developed. Drugs do not cure. They make possible psychotherapy and guidance; they develop one's competency through the resolution of fear, hostility, guilt, depression, excitement, and exaltation, which interfere with one's effective performance of functions and work. (See *Psychopharmacology*)

Where is psychiatry headed?

Psychiatry is expanding its sphere of activity and the scope of its fields of inquiry. More and more areas of human learning and activity are being related to psychiatry, and psychiatry is using more and more the contributions of other disciplines in its search to understand the mind and in its attempt to help the emotionally ill. At present, there is tremendous interest in nonpsychological methods of approach, and

a growing tendency to see the psychiatrist as the leader of the psychotherapeutic team and not solely as a practitioner of psychotherapy. There will be less isolation of psychiatry from the community and from other branches of medicine. There will be increasing community psychiatry, that is, nonhospitalized psychiatry. There will be more personnel from many disciplines involved in treatment. There will be increasing contributions from the chemical, molecular, and the pharmacological sciences. Knowledgeable clergy, teachers, family agencies, and public health nurses will enter more and more into the psychiatric problems of the community. Mass media of communication such as television, radio, newspapers, and magazines will provide increased information about psychiatry. New developments may even be expected from the computing machines. There will be great expansion of child study centers, of research in child development, of studies in the detection of childhood tendencies toward psychiatric disorders, and of child and parent guidance centers.

PSYCHOANALYSIS

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What is psychoanalysis?

Psychoanalysis is primarily thought of as a method of therapy for emotionally disturbed individuals. However, it is more broadly a scientific method of observation of certain mental and emotional phenomena. These phenomena are generally called "subjective" or "imaginary" in contrast to those usually considered "objective" or "real." On the basis of observations made by means of its specific method, psychoanalysis has gathered a body of knowledge about these phenomena and has formulated a series of hypotheses to explain and synthesize its observations, in the same way as is done in other fields of science. These theories and hypotheses are conceptualizations which correlate the findings under certain guiding principles. They are not fixed and immutable, i.e., not dogma, but are subject to reformulation as more and more observations are made. Thus psychoanalysis is in a state of flux and change, as are all sciences.

Psychoanalytic concepts have applicability in any field of human endeavor into which the nonrational elements of human thought and behavior enter, e.g., anthropology, sociology, history, etc., as well as in the humanities and the arts. This does not mean that psychoanalysis can "explain" these fields, but it can help in the understanding of certain aspects of them. (See *Creativity*)

What is the subject matter of psychoanalysis?

Psychoanalysis chose for its sphere of observation precisely those areas that, in general, are considered interferences in other scientific fields—the subjective distortions, "accidents," illogicalities, etc., that are annoying and irritating, and that are usually dismissed or disregarded. In view of the ubiquity of their occurrence in human life, psychoanalysis posed the question of their significance and function. Thus it undertook to observe the nonrational in human beings. Included in this area are: dreams, daydreams, fantasies, nightmares, feelings,

emotions, impulses, prejudices, slips of the tongue, posture, gestures, voice inflections, etc., in short, anything that goes beyond the logical, rational, objective, and conscious. (See *Dreams; Sleep; Emotions; Communication and Mental Health*)

Logical thought and rational action per se are not within the realm of psychoanalytic observation. They represent a common pathway of expression deriving from many sources, some objective, some subjective. It is essentially the latter that lie within the realm of psychoanalysis.

What are the underlying principles, assumptions, or concepts of psychoanalysis?

Underlying the structure of psychoanalysis both in theory and in practice are certain fundamental concepts, some of which are explicit, some implicit.

1) The Assumption of Psychic Determinism

This is the most fundamental explicit principle in psychoanalysis. It forms the basis for the development of the whole structure of psychoanalytic observation and theory. It represents the extension into the psychic sphere of physical determinism (causality). It states that just as we accept the fact that nothing in the external world occurs at random or by chance, so in our mental life random accidental occurrences only appear so on the surface. However, one of the characteristics of psychic phenomena is that they invariably are determined by multiple factors, rather than by a single factor, i.e., they are "overdetermined." Thus it is that while we can demonstrate "necessary factors" for psychic phenomena, we can rarely (if ever) demonstrate "sufficient factors." It can be shown that determining factors can be found for all psychic phenomena, although they may be more or less difficult to demonstrate in a given case. Very frequently the individual concerned is not aware of these antecedent factors, i.e., they occur on the basis of unconscious mental activity.

2) The Concept of Unconscious Mental Activity

This is the second explicit principle of psychoanalysis. It states that a large part of the mental activity going on in both normal and abnormal individuals is unconscious, i.e., goes on without awareness on the part of the individual. This, in psychoanalytic terminology, is referred to as "primary process." Unconscious mental activity has char-

acteristics that are different from conscious mental activity, which psychoanalytically is referred to as "secondary process." Secondary process activity is characterized by what is ordinarily called logical rational thought.

Primary process activity, however, has characteristics that at first strike us as strange and peculiar. It shows a lack of any sense of time, it tolerates mutual contradictions, it has no sense of negation, it tolerates opposites, it combines different parts of objects or attributes of people without difficulty, it lacks relation to external reality, and it frequently presents itself in visual form. Most of these characteristics are easily recognized in dreams. However, they are also easily observable in the mental life of young children (which is one reason they are referred to as primary processes). But also in adult life they play a much greater role than one ordinarily suspects, for example, in much of our common manner of speaking. Primary processes play an important role in wit and humor, as well as in poetry and art, in advertising, and particularly in symbolism. This type of thinking becomes abnormal only when it assumes a dominant role in the adult. Then we call such a person "psychotic." (See *The Unconscious*)

3) *The Evolutionary Concept*

This is perhaps the most important and fundamental implicit principle in psychoanalysis. The whole theoretical structure of psychoanalysis may be viewed as the most consistent application in the field of human psychology of Charles Darwin's evolutionary theory. From this point of view, psychoanalysis is the study of the evolution and development of the human mind. The evolutionary principle furnishes psychoanalysis with a firm biological base in the organism as a whole, to which it always returns. Thus psychoanalysis constantly seeks to correlate psychological phenomena to an ultimate origin in the biological sphere.

4) *The Genetic Concept* (a corollary to the evolutionary concept)

It states that the enormous diversity of human psychic activity in the adult has its origins in the relatively simply psychological and biological phenomena of infancy and childhood. All human psychic activity is viewed as arising ultimately from early primitive psychophysiological manifestations in childhood. It was on the basis of this concept that Sigmund Freud discovered the significant variable of psychosexual development around which to orient his observations and theoretical

formulations. He observed that sexual activity (defined in psychoanalytic terms as pleasure-giving activity in the broadest sense) does not arise as something new at puberty, but originates far earlier in human development, indeed is present from birth on.

On the basis of these observations Freud formulated the libido theory. Libido is defined as sexual energy in the broadest sense. It is invested in various parts of the body at specific periods of life and follows an orderly sequence of development. Early in life it centers primarily around the orifices of the body, which represent the infant's physiological communications with the external world. Thus Freud distinguished as the earliest psychosexual developmental stage, the oral phase, in which the infant experiences pleasure and displeasure, gratification and frustration through the mouth (and its extension, the digestive tract). This phase covers the period of the first year of life. The psychic experiences during this phase center around the mother figure and furnish the prototypes for a host of emotions and reactions in later life relating to basic attitudes and ways of reacting to and responding to the external world.

The second stage, the anal phase, extends approximately through the second year of life. This phase has to do with the establishment of fecal excretory habits and all the groups of emotionally significant factors relating to this. It also becomes the prototype of a host of complex psychological elaborations relating fundamentally to feelings and attitudes toward the integrity and autonomy of one's body.

The phallic phase, from the third year through the fifth or sixth year of life, has to do with the investment of libido in the genital zone as a source of pleasure-giving sensations. Again, the prototypes of multitudinous reactions can be traced back to varying sensations that arise at this period in this region and the resultant gratifications and conflicts engendered thereby, which are directly related to the family, particularly to the parents. This is the period in which the "Oedipus complex" (or more generally, the "oedipal situation") occurs. It refers, in its most universal sense, to intense positive, negative, and mixed emotional reactions on the part of the child to the adults who rear him, usually, of course, the mother and father, and to the fantasies that arise in relation to these feelings.

Following the phallic or oedipal period the child enters a period called latency, which extends until puberty. In this period the intense and rapid fluctuations of emotion subside, at least relatively speaking. There are two interesting things that may be noted regarding the end

of the oedipal period. The first is that most individuals have an amnesia for their early childhood, i.e., for events before the age of five or six. Although many remember isolated incidents from these early years, most people have no feeling of continuity of memory and personality as they have for the events and feelings of the post-oedipal years. Secondly, most societies begin the acculturation of the child at about this age, i.e., the beginning of the preparation of the child for his place in society, in the form of education through schooling or training in various skills. Following latency the child enters puberty and adolescence, and progresses toward adulthood.

This, in a very schematic and oversimplified way, represents the theoretical structure that derives from the genetic principle in psychoanalysis. This principle, it should be noted, distinguishes psychoanalysis as such from many other psychologies. Although psychoanalysis shares many things with other psychologies, in its genetic, evolutionary base, it is unique. (See *Psychosexual Development in Man*)

Freud, in his first theoretical formulation, conceived libido as deriving from drives originating from various organs within the body. Juxtaposed against the direct discharge of libidinal energy were the ego or self-preservative drives, the nature of which were never clearly specified.

5) *The Pleasure Principle and the Reality Principle*

According to psychoanalytic theory, the libidinal forces, once activated, seek discharge as rapidly and directly as possible without regard to the effect this may have on the integrity of the total organism. This process of direct discharge is called the "primary process," and the principle related to it is called the "pleasure principle," i.e., the seeking of gratification or "pleasure" through immediate discharge. However, such direct discharge must be subordinated to the demands of reality and the survival of the organism. Therefore, immediate discharge is rarely possible and must be long-circuited. This long-circuiting is called the "secondary process" and is related to the "reality principle," namely, the principle that gratification must at times be postponed or delayed in order for the person to find greater gratification at a later time. The secondary process is more organized than the primary and manifests itself principally in logical, rational, reality-oriented thought.

Freud went "beyond the pleasure principle" and reformulated his theoretical structure to include what he called the "repetition com-

pulsion," i.e., the need to repeat experiences even though unpleasant or harmful to the organism. This was conceptualized in the form of the life and death drives (Eros and Thanatos). Aggression, which had hitherto been considered a secondary phenomenon resulting from frustration, now became, in this second theory, a primary drive. (See *Aggressions*)

This latter theory has never been accepted in toto by all psychoanalysts, partly because it seems to contravene the basic evolutionary principle upon which psychoanalysis is based.

6) *The Dynamic Principle*

The Freudian concept of neurosis is based upon the principle of a conflict between two opposing forces arising within the individual. The resultant compromise is the manifest neurosis.

This dynamic principle of conflict has been quite widely accepted in the fields of psychiatry and psychology, in contrast to the genetic concept. (See *Neuroses*)

What is the history of psychoanalysis?

The history of psychoanalysis is dominated by the work of its chief architect, Sigmund Freud (1856–1939). Schematically it may be divided into several periods:

1) Prehistory (1880–1900)

This period dates from Freud's early work in medicine and neurology and his gradual shift of interest from neurology to psychology under the influence of Jean Martin Charcot, Hippolyte Bernheim, and the general scientific climate of his time, including particularly the evolutionary theory of Charles Darwin. The earliest preanalytic work, particularly with Josef Breuer, belongs in this period.

2) Beginnings of Psychoanalysis Proper (1900–1905)

This was a period of pioneering and beginning recognition for Freud. It began with the publication of *The Interpretation of Dreams*, one of Freud's greatest achievements. It also represents the period during which psychoanalytic principles were applied to normal phenomena, such as "psychopathology of everyday life," wit, humor, etc. During this time Freud further refined his technique and began to arouse greater interest among his colleagues.

3) Growth and Development (1905–1913)

In this period the psychoanalytic movement as such began to develop. Freud attracted followers in various parts of the world. Psychoanalytic concepts were applied to many different fields.

4) The “Heroic” Period (1913–1920)

This period was inaugurated by a series of papers that attempted to synthesize and encompass in theoretical formulations all the findings that had been made up to that point. This was done in a series of papers called, “Papers on Metapsychology.” Inherent in these formulations was the beginning recognition of a need for a theoretical reformulation that occurred in the next period. During this period there was a great development in the psychoanalytic movement, which now became international, and also the beginning of the first schisms within the movement itself (as a result of the work of Alfred Adler, Carl Jung, and somewhat later, Otto Rank).

5) Theoretical Reformulation (1920–1926)

This period included the introduction of the “structural concept,” a concept that remains with us at the present time. This concept divides the mind into three structures: id, ego, and superego, each of which has particular mental functions and activities. The id is the seat of unconscious mental activity and contains the driving forces within the individual. The ego relates the individual to the external world and is the seat of conscious activity, but is also in part unconscious, and is the source of “character.” The superego contains what is usually referred to as “conscience,” but is also to a great extent unconscious.

6) Ego Psychology (1926–1939)

Essentially, this was a period of philosophic application of psychoanalysis and of development of an “ego psychology.” The psychoanalytic movement still remained fairly united, aside from the aforementioned early schisms.

7) Divergent Groups (1939–1950)

This was a period of further refinement in the field of ego psychology with no essentially new formulations. Within the psychoanalytic movement, however, there was the beginning of the formation of divergent theories and schools.

8) New Horizons (1950–present)

This is a period of theoretical questioning in which we still find ourselves. There is an increasing recognition of the need for a broader theoretical base—but there is no final resolution of this problem to date. (See *History of Treatment of Mental Disorders*; Sigmund Freud)

Who are the men prominent in this field?

Essentially, of course, psychoanalysis has been dominated by the genius of Freud for most of its existence. Many others have contributed greatly, but the main body of psychoanalysis, both in theory and practice, rests upon the contributions of Freud. Among the earlier followers of Freud (“the first generation”) one might mention Karl Abraham, Sandor Ferenczi, Ernest Jones, etc. Adler and Jung also belong in this period, although they split away very early. However, none of these men made really significant original contributions to the theoretical structure of psychoanalysis. Rather, they elaborated on one or another particular aspect of Freud’s work.

A later generation of psychoanalytic contributors who further developed Freud’s work includes, among others: Franz Alexander, Erik Erikson, Otto Fenichel, Anna Freud, Heinz Hartmann, Abram Kardiner, Ernst Kris, Sandor Rado, Robert Waelder, etc.

Since Freud’s death, separate schools have developed around such figures as: Erich Fromm, Karen Horney, Melanie Klein, Wilhelm Reich, Theodor Reik, Harry Stack Sullivan, and others; but no major reformulations have been achieved that encompass in a coherent body of theory the observed data of psychoanalysis.

Hartmann, in his work, has attempted to supplement and modify certain aspects of the basic theoretical structure. Erikson has also amplified and enlarged the existing framework of psychoanalysis in order to encompass much that did not adequately fit therein. Psychoanalysis, like many sciences in our time, has amassed much data that goes beyond its present theoretical structure, but it has not yet found any person who has been able to synthesize this in a more adequate framework than the existent one.

Is hypnosis used in psychoanalysis?

In psychoanalysis proper, hypnosis is no longer used. It does, however, have a legitimate and valid usefulness in dynamically oriented psychotherapy based upon principles derived from psychoanalysis.

Psychoanalysis, in terms of its origin, owes a considerable debt to hypnosis. The stimulus for the development of psychoanalysis derives from Freud's work in hypnosis with Charcot and Bernheim. The trigger for the formulation of the concept of unconscious mental activity arose from observations related to the phenomena of posthypnotic suggestion. Freud originally utilized hypnosis in the treatment of his patients and gradually evolved the psychoanalytic technique from the hypnotic technique. (See *Hypnosis*)

How many psychoanalysts are there in the United States?

Since there are no legal restrictions on the use of the word, "psychoanalysis," and since it has high prestige value, it is preempted by many people, both medical and nonmedical.

The American Psychoanalytic Association, the official branch of the International Psychoanalytic Association, has approximately 1,000 members. In addition, there are approximately 1,000 psychiatrists who are students in the seventeen psychoanalytic institutes throughout the country. (Some idea of the relation of the field of psychiatry to psychoanalysis may be gained from the fact that the American Psychiatric Association, the official psychiatric body in the United States, has a membership of approximately 12,000. Most, but not all, of the members of the American Psychoanalytic Association are also members of the American Psychiatric Association.)

Unfortunately, there are a number of peripheral groups that require no particular training or qualification, but exploit the term "psychoanalysis" for commercial purposes. Tragic as this may be, there is little that can be done about it under the existing legal system. In this respect, psychoanalysis is no better off than many other fields of medicine in which quackery flourishes to the detriment of the patient.

What are the major psychiatric problems with which psychoanalysis deals?

The classical method of psychoanalysis was designed to deal with a category of emotional disorders called psychoneuroses. These include the conversion hysterias, the anxiety hysterias (phobias), and the obsessive (or obsessive-compulsive) neuroses. However, since Sigmund Freud's original work, the scope of application of psychoanalysis has been extended to include character disorders, so-called borderline states, and even psychoses. (See *Mental Mechanisms; Character Structure*)

Is psychoanalysis used in mental hospitals? Is it useful in the treatment of psychoses?

Psychoanalytic principles are now used quite widely in many mental hospitals in the United States. Under the name of psychodynamics, they are sometimes used even in those institutions that ostensibly shun psychoanalysis. However, psychoanalysis, in the strictest sense, is not used in most mental hospitals, although there are a few small private institutions in which psychoanalytic methods, suitably modified, are being utilized.

As yet there is no consistent, modified method that can be used in a large variety of cases. There have been numerous clinical instances in which such modified psychoanalytic therapy has been successful in the treatment of psychotic individuals. (See *Psychoses; Mental Hospitals; The Mental Patient*)

What is the relation of psychoanalysis to psychiatry and psychotherapy?

Psychiatry is a branch of medicine that deals with mental and emotional illness. Psychoanalytic concepts have profoundly affected all areas of psychiatry—indeed, they have affected medicine as a whole.

Psychotherapy is a term for a group of methods of treatment for mentally and emotionally disturbed individuals, all of which use primarily psychological means to influence and bring about changes in such individuals. There are many different forms of psychotherapy, of which psychoanalysis is one. Psychotherapy may be juxtaposed with the organic therapies in which physical methods (drugs, electroshock, insulin, fever, etc.) are used to influence the psychic state of an individual. These two types of therapy are not in opposition to each other and may be used in instances to supplement each other.

There are innumerable psychotherapeutic approaches. However, broadly speaking, psychotherapists may be divided into those who use dynamic principles as an approach, i.e., view emotional and mental illness as based on conflicts within the individual or between the individual and his environment, and those who are nondynamic in their approach, i.e., do not consider conflicting forces as a significant factor in generating mental illness. The nondynamic psychotherapists tend to look upon the emotionally sick individual as a "black box" and are not particularly interested in emotional conflict as such. They use such techniques as authority, persuasion, exhortation, appeal to reason, etc., in attempting to force or persuade patients to relinquish their symptoms.

The dynamic psychiatrists may be divided into various groups, depending upon their conception of the dynamics of mental or emotional illness, and of mental phenomena in general. Most dynamic psychotherapies derive in one way or another from the dynamic principle of psychoanalysis.

On the one hand, there are groups that formulate the concept of dynamics in the sense of forces within the psychic structure of the individual that bring him into conflict with the environment.

On the other hand, there are groups which formulate the concept of dynamics in the sense of forces and counterforces within the psychic structure that create conflict within the individual that may or may not reflect itself in conflict with the environment.

Various "schools" of psychoanalysis may be considered to have developed from the relative significance or weight given the role of interpsychic *vs.* intrapsychic factors. At one pole are those "schools" that have been called "culturalist" or "environmentalist" and that stress the interpersonal or interpsychic difficulties as primary and regard intrapsychic conflict as secondary, or even arising principally as a result of conflict with the environment. The classical psychoanalytic approach is at the other pole. It stresses the significance of intrapsychic factors as primary, but it does include the role of environmental pressures. (See *Psychiatry; Psychotherapy*)

What is "free association"?

A special technique or instrument is required in every science in order to observe its particular aspect of natural phenomena. In psychoanalysis it is "free association," developed in order to reduce the role of logical thought and purposive action so that the nonrational subject matter could be adequately observed.

"Free association" is the process whereby the patient says everything and anything that comes to his mind without regard to its seeming relevance, coherence, logicity, significance, acceptability, morality, or to any ordinary principles or conventions that restrict our usual social intercourse. This may seem simple and easy to do. In actuality, it is extraordinarily difficult. If you try it yourself in complete privacy, you will see how quickly unwelcome, unpleasant, "silly," "trivial," unacceptable thoughts and feelings come to mind and how rapidly one finds oneself "blocked," i.e., with the feeling that one's mind is a blank. However, in the psychoanalytic situation the efforts that the patient makes, the blocks that stop his associations, the gaps that appear in the

course of associating, can also be used to explore and elucidate the nature of the phenomena of psychoanalysis. In fact, they yield important data regarding the nature of the patient's difficulties and the problem areas that are helping to create them.

In order to facilitate "free association," it is best for the patient to come to the same quiet setting at fixed regular intervals of time.

What happens in psychoanalysis?

An emotionally disturbed individual, after a period of distress, makes an appointment with a psychoanalyst. On the appointed day he appears in the waiting room and finds himself alone, or perhaps in the presence of a secretary. There are no other patients waiting. Within a very short time he is ushered into an office that usually is rather quietly and comfortably furnished, offered a chair, and asked to talk about himself and his difficulties. The psychoanalyst listens, occasionally makes a comment or asks a question, perhaps makes a few notes. For the most part the patient talks, the analyst listens. Most patients pour out their stories without much difficulty. They have held their troubles within themselves too long and welcome the opportunity to talk to someone who listens so readily. After about forty-five or fifty minutes the analyst may interrupt, discuss practical matters, and indicate whether he feels that psychoanalysis may be useful. If so, he makes the necessary preliminary arrangements regarding time, fees, etc., perhaps gives a few instructions regarding promptness and regularity, and discusses briefly the use of the couch and "free association."

During the next interview he may obtain additional background information and settle any further practical details. Within a few interviews he has the patient lie on the couch and instructs him briefly in the use of "free association," i.e., encouraging him to say anything that may come to his mind. During each subsequent hour the patient talks, the analyst listens, occasionally making a comment, an interpretation, or asking some question.

On the surface the whole procedure seems rather casual, haphazard, and even unscientific. It certainly is far from what a patient usually expects when he goes to a doctor. However, subsequent sections will demonstrate that this procedure is in fact based on a scientific method.

This process continues three to five times weekly for many months, often years. In the interval hundreds of hours have gone by, and untold thousands of words have been spoken, primarily by the patient.

During this time the patient has talked of many things: what is going on in his present life, his past life, his childhood, his growing up, his parents, his brothers and sisters, his friends and his enemies, his loves and his hates, his accomplishments and disappointments, his dreams and fantasies, his feelings of pleasure and pain, his guilts, his anxieties, his fears, his family, his work, his ambitions, of trivial things, of important things, of his feelings about his psychoanalyst—in short, about everything that has happened to him in one way or another and how he has felt about it and reacted to it. This is of an intensely personal and private nature.

At times he talks freely and easily, at other times he resists, is silent, feels angry and frustrated, reproaches the analyst for not helping him more, asks for advice, guidance, and direction, and resents not getting it. Inevitably, as a result of the frequency of his visits and the nature of the subject matter he brings forth, the patient develops intense feelings toward the person of the psychoanalyst. The psychoanalyst, however, remains relatively neutral and objective throughout. The patient finds that he experiences feelings toward the psychoanalyst similar to those he felt toward other significant figures in his life, i.e., he “transfers” to the psychoanalyst both positive and negative feelings that are not appropriate to the situation but that nevertheless inevitably appear.

Throughout this process the psychoanalyst's role is to listen hour by hour to the patient's free associations with a corresponding “free-floating attention,” that helps him to see the hidden connections underlying the patient's associations. He then, at appropriate times, interprets these to the patient, i.e., tells him what he feels the patient has been trying to express without realizing it. He tries to ease the way for the patient to construct a coherent continuous picture of his life, to help him express his negative, as well as positive, feelings. He does this by pointing out various resistances (blocks) as they arise, and making the patient aware of the reactions he has transferred to the analyst. His goal is to enable the patient to function as an individual in his own right with due understanding of his inner needs and of external exigencies.

Gradually, as the patient exposes more and more of his inner feelings and thoughts, he begins to understand things about himself and his reactions of which he was not previously aware. He connects ideas, events, feelings that hitherto seemed to have no connection, by recognizing his own role in them. He explores the origins of his diffi-

culties and problems extending far back into his early life. He finds that with this knowledge about himself he can now *choose* to act or do things that he previously felt *forced* to do. In short, he gradually frees himself of the neurotic symptoms that brought him to psychoanalysis, and in the process learns a great deal about himself and his relations with others that he never knew before.

Out of this mass of material emerges a picture of each individual life that equals in intensity and grandiosity the portrayal of human suffering and human life in the great novels and art of civilization. Each individual who undergoes analysis emerges as a prototype of humanity as a whole—each different and unique as an individual, but also having feelings and thoughts common to all mankind.

This is the process of psychoanalysis as it is used therapeutically.

How can one find a qualified psychoanalyst?

In the medical profession, as in other professions, there are standards that ensure a certain level of competence. In medicine in general these are furnished by graduation from a recognized medical school, licensure by a state board of medical examiners, and, for specialists, certification by the certifying boards in each field, which guarantee a basic amount of training, education, experience, and knowledge in the particular field.

All psychoanalytic institutes and schools require a specified course of education and training. Membership in the American Psychoanalytic Association is similar to certification by specialty boards in other fields of medicine. The institutes affiliated with the American Psychoanalytic Association function as postgraduate educational and training schools in psychoanalysis, with rigorous requirements.

Psychiatric residency education is a prerequisite for acceptance into psychoanalytic training. Postgraduate work in psychoanalysis consists of three separate but interrelated parts: (1) a personal psychoanalysis by a qualified training psychoanalyst, (2) a course of study of psychoanalytic theory and practice, and (3) control work, in which the student psychoanalyses patients and consults regularly with a senior psychoanalyst regarding the course of treatment. After completion of this work the student is usually required to take a comprehensive examination or write a thesis in order to be accepted as a qualified psychoanalyst.

Hence, for the troubled individual, consultation with a recognized psychoanalytic institute in his area assures him of seeing a qualified

psychoanalyst, just as consultation with a local medical society assures him of finding a qualified physician.

What is a "lay" analyst?

A "lay" analyst is an individual who conducts therapy according to psychoanalytic principles, but who does not hold a medical degree from a recognized medical school.

How can a prospective patient decide whether a particular psychoanalyst is the right one for him?

There are no objective criteria by which such a decision can be made. The decision should be a mutual one on the part of the psychoanalyst and of the patient. Many psychoanalysts use what is called a "trial period" immediately following the initial decision to start psychoanalytic treatment. This is usually structured in such a way that the patient and the psychoanalyst agree to work together for several weeks, at which time a decision will be made as to whether each feels that he can work with the other. This enables the psychoanalyst to evaluate certain underlying aspects of the patient's emotional difficulties that may not have been immediately apparent during the initial evaluation, as well as permitting the patient to evaluate his own subjective reactions to the psychoanalyst as a person. In practice, if the working arrangement is mutually satisfactory, the transition to psychoanalysis proper is made without any formal acknowledgement thereof.

No matter how rigorous the education and training of a particular psychoanalyst may have been, he still retains his own particular individuality and personality. If, on one side or the other, there is a personality clash that goes beyond the bounds of the psychoanalytic situation, a change should be made. The psychoanalyst must have the honesty and integrity to face his reactions to the patient and suggest a referral, and the patient should have the courage and the courtesy to inform the psychoanalyst of his feelings and be able to express them.

Should an individual select an analyst on the basis of the analyst's "school" of psychoanalytic theory?

The primary and fundamental question is whether the psychoanalyst is a qualified, competent, and ethical individual rather than whether he adheres to a particular theoretical orientation. Member-

ship in one or another of the recognized organizations guarantees at the least a certain minimum training and experience.

In general, from the patient's standpoint, the skill, competence, training, and above all the integrity, empathy, and honesty of the particular psychoanalyst is of more significance than the particular "school." It does not matter, from the point of view of the patient's suffering, whether he is relieved through the therapy advocated by Freud, Jung, Adler, Sullivan, etc.

The medical function of therapy is to relieve the suffering of the patient, not to prove or disprove a particular theoretical orientation. The fact that all "schools" claim successes (and also admit to failures) simply demonstrates our need for further research and more encompassing theoretical conceptualizations to explain the complexities of human psychic functioning and malfunctioning.

Should an individual choose psychoanalysis rather than psychotherapy or group therapy?

An individual does not, or at least should not, choose one method of psychological treatment rather than another. This is a matter to be decided by a qualified physician after careful evaluation and diagnosis. Whether psychoanalysis, psychotherapy, group therapy, or other forms of psychiatric care are indicated depends upon the nature of the emotional problem, the objective circumstances of the patient's situation, and numerous other factors that enter into the decision of the physician. This decision is a complex problem that requires expert clinical judgment.

Does a psychoanalyst ever refuse to accept an individual who desires therapy? If so, why?

Not all emotional problems or mental illnesses are amenable to psychoanalysis. Psychoanalysis is a therapeutic method that requires the investment of a tremendous amount of time, energy, effort, and money. It is not to be entered into lightly or casually. The psychoanalyst must do a careful clinical evaluation of his patient with regard to the nature of the problem, its amenability to the psychoanalytic method, the motivation of the patient, his psychological-mindedness, his ability to tolerate the stresses of the analytic process, and many other things, before prescribing psychoanalysis.

There are contraindications as well as indications for psychoanalysis, as for any other type of medical treatment. The psychoanalyst should

be familiar with the various methods of treatment in psychiatry. If he is not expert in these areas, or if he does not wish to utilize them, he should make the necessary referral to another analyst or psychiatrist.

How does the psychoanalyst gauge an individual's progress?

There is no single or simple criterion by which progress may be judged. A relative gauge is represented by manifest behavioral changes as seen in or reported by the patient. The subsiding of neurotic symptoms (anxiety, tension, insomnia, phobias, compulsions, obsessive thoughts, sexual inhibitions or fears, etc.) or changes in hitherto fixed ways of reacting to situations may be evidence of change and progress.

More subtle evidences of progress, evident only within the psychoanalytic situation, are such things as the ability of the patient to associate to dreams and fantasies, to bring in material about hitherto taboo areas, to recall, with the appropriate associated feelings, hitherto forgotten memories and experiences, etc.

Perhaps even more subtle is the increase in the ability of the patient to grasp psychological connections between various hitherto unrelated experiences, to find meaningfulness in things hitherto felt as meaningless, to feel and reveal emotions in relation to the psychoanalyst and relate these to previous experiences with other significant people in the patient's life, and to connect these with experiences and reactions to the external world. An additional significant factor lies in changes in the patient's concept of himself.

Last, perhaps most subtle of all, is the patient's ability to feel free to choose one course or another, and thereby to find pleasure and obtain gratification from what he does, whether in work or play. It is only through feeling that we have some freedom of choice, tempered by and related to the realities of the world in which we live, that we can achieve pleasure and gratification and occasional moments of happiness.

Is an individual able to determine his own progress in psychoanalysis?

The patient himself is often able to judge specific aspects of his own progress in psychoanalysis, but not fully. In a general way he uses criteria similar to those used by the psychoanalyst. But his evaluation is, of course, much more subjective than that of the psychoanalyst.

Such things as the subsiding of symptoms, changes in behavior, increased freedom of action, changes in feelings about oneself, and the ability to experience pleasure and gratification in the outside world

are fairly obvious. However, the patient is often less aware of how significant or far reaching such changes may be than is the psychoanalyst.

Paradoxically, what may be felt by the patient as an aggravation of his condition, may under certain circumstances be an indication of progress, e.g., the appearance of anxiety in a compulsive patient who has hitherto avoided anxiety by intellectualizing, etc.

A subjective reaction in the early weeks or months of psychoanalytic therapy is so frequent that it has been called a "flight into health." In this, on the basis of the beginning understanding of some aspects of his problems and the nonjudgmental tolerant acceptance of the analyst, the patient may experience a sudden relief of many of his painful symptoms and feel (falsely) that he has been cured. Experience has shown that this "flight into health" is often illusory and transitory.

Is it likely to be extremely difficult for the patient himself to end his association with his psychoanalyst?

If the intense transference relationship, which is an inevitable concomitant of the psychoanalytic process, is not resolved, or is inadequately resolved, separation from the psychoanalyst may be extremely difficult. This means that the psychoanalytic process has not been sufficiently worked through.

In a well-conducted psychoanalysis this is usually not true. The essence of psychoanalytic therapy lies in the resolution of the transference relationship to as great an extent as possible. This implies that the patient is able to view his psychoanalyst in realistic perspective as a physician with skill and competence and as a human being with strengths and weaknesses.

Does the psychoanalyst sometimes suggest to the patient that psychoanalysis be ended?

Termination of psychoanalysis is usually by mutual agreement. In a well-conducted psychoanalysis the initiative usually comes either explicitly or implicitly from the psychoanalyst, who is ultimately responsible for treatment and for the care of the patient. The optimal time for termination is a difficult and delicate decision that requires careful and skilled observation and evaluation. The criteria, of course, vary with each individual case. In general, one might say that termination comes when both psychoanalyst and patient agree that the major areas of discomfort and disturbance in the patient have been reasonably

resolved and that the patient is able to function adequately and to obtain reasonable gratification in his life, external circumstances permitting.

Under certain circumstances a psychoanalysis may be terminated by the psychoanalyst when he feels that the introspection and self-examination inherent in the psychoanalytic process may be harmful to the patient, i.e., may result in an exacerbation of symptoms and problems with which the patient would be unable to cope. This, again, is a clinical decision that requires careful observation and evaluation. One might compare it to a surgical procedure, which, although theoretically indicated, may result in a disability or incapacity to the patient more crippling than the original condition itself.

The goal of psychoanalysis is neither to achieve happiness for the patient nor to solve all his problems. Rather, it is to permit the individual to experience satisfaction and happiness when the external circumstances permit, as well as sadness or anger, etc., when the objective situation justifies these; in other words, to cope with the problems, difficulties, and frustrations that every human being must face in life without internalizing or externalizing them in a destructive way.

Happiness is not an intrinsic goal of psychoanalysis. To use Freud's oft quoted phrase, "If we succeed in transforming . . . neurotic misery into common unhappiness . . . with a mental life that has been restored to health, we will be better armed against that unhappiness."

PSYCHOLOGICAL TESTING, INTRODUCTION TO

by MOLLY HARROWER, PH.D.
New York

The psychologist, using various psychological and mental tests as his professional equipment, is rapidly becoming an important and well-integrated part of the community mental health resources.

In the articles on testing the reader will be able to learn in some detail how intelligence, aptitude, and psychodiagnostic tests are used. Stated in another way, he will discover how the psychologist is employed in the educational, industrial, and medical fields, respectively. The articles also discuss the kinds of services which the psychologist offers, and the types of problems to which he can reasonably be expected to offer assistance.

Psychological tests are constructed for many different purposes and, depending on the problem initially posed, the psychologist will select and use different kinds of tests in order to come up with relevant information.

For example, tests pertaining to a child's level of intelligence may be used to see whether or not he is employing all his available ability in his schoolwork. They might be used to ascertain whether or not the child is a candidate for a school for especially bright youngsters or, at the other end of the spectrum, whether his lack of intellectual endowment might indicate that he should be placed in a special class, rather than be expected to cope with schoolwork outside the range of his ability. The aim of these tests is to place children in the appropriate setting for the best possible use of their particular intellectual equipment. (*See Intelligence; Intelligence Testing*)

Psychological testing in another field might have as its aim the evaluation of the seriousness of an individual's emotional problems. Psychological tests, in this case, are spoken of as *psychodiagnostic* tests, and are used, along with other information about the patient, to decide whether or not an emotionally distressed person could be helped by a period of hospitalization in a psychiatric institution. Such tests also indicate the most appropriate treatment the patient should receive. (*See Psychodiagnostic and Personality Testing*)

The aim of another type of test is to help a student or a teen-ager choose a profession or the field of work or employment he wishes to enter. A vocational counselor in school, or college, may use such tests to indicate aptitudes and interests to discover where the student's abilities lie. In somewhat the same way, tests of interests and aptitudes may be used to rule out individuals who are unfitted for the performance of certain tasks. In the industrial field, for example, certain individuals can happily perform routine tasks, while others require greater scope for their initiative and imagination. (See *Aptitude and Vocational Testing*)

Psychological tests are extremely numerous, running into the thousands. In *The Fifth Mental Measurement Yearbook*, for example, it required over twelve hundred pages to catalog and describe those tests which had been standardized over a four-year period.

Psychology is a fast-growing profession. Psychologists who belong to the national organization, the American Psychological Association, number nearly twenty thousand, and in New York State alone, nearly three thousand psychologists have been certified by the state as professionally competent and entitled to offer their services to persons who may desire testing or counseling.

And who are the people who need or desire testing? Who can benefit from the psychologist's services? Answers to these questions will be found in the articles on testing.

The emphasis placed on psychological tests in other countries is somewhat different from that in the United States. Although a Frenchman, Alfred Binet, developed the forerunner of intelligence tests as we know them today, American psychologists have busied themselves with standardization and validation of such tests on a large scale, and along lines which were probably not even originally contemplated. In Germany and Switzerland more interest is to be found in tests that some American psychologists think do not appear to be sufficiently standardized. Among the projective techniques, for example, graphology, or the study of handwriting, holds a much more important and respected place in Europe than it does in the United States today. In Russia the emphasis is much less on psychological tests, as we know them, than it is on the specialized study of an individual's defects, with emphasis on why the individual fails to achieve, or how he succeeds.

How expensive is psychological testing? Are its costs prohibitive? No, it is safe to say that the costs for psychological services are in no way out of line with the other professional services in the mental

health field, or indeed in the health field in general. A thorough and detailed psychological examination, whether it is given by an agency or a psychologist in private practice, will probably cost around \$75. To train a psychologist takes many years, so that when he makes a professional judgment, or writes a report about a child whom he has tested, he is actually making available to his client the fruits of many years' experience and training.

It is hard to say how much a single test will cost, for tests are rarely paid for as individual items. Rather the psychologist will charge for the time needed to conduct the test, the time needed to score and evaluate the findings, and the time needed to write a report that will be meaningfully related to the problems which his client has presented.

Can tests be oversold? As we all know, advertising sometimes makes exaggerated claims even for an excellent product. Occasionally it happens that psychologists may become overenthusiastic about some test, and allow their enthusiasm to affect their judgment. But most responsible and well-trained psychologists will be likely to make a rather conservative estimate, rather than a grandiose one, of what can be gained from their services. With an increasing number of states requiring certified psychologists, there is less and less chance of the public being misinformed or misled.

PSYCHODIAGNOSTIC AND PERSONALITY TESTING

by MOLLY HARROWER, PH.D.
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What is a psychological test? What is a psychodiagnostic test?

A psychological test is a standardized device for measuring or evaluating some aspect of an individual's behavior, his mental and emotional endowment.

A psychodiagnostic test is a standardized device for measuring or evaluating personality and behavior, especially disordered behavior, which employs the techniques of clinical psychology.

Psychological testing is the use of one or several of these devices by trained personnel, in order to assess an individual's psychological makeup.

When are psychodiagnostic tests recommended and by whom?

The usual procedure is to use psychodiagnostic tests after the appearance of a problem or symptoms. The troubled person usually seeks out someone whose business it is to give guidance, counseling, or psychotherapy. If the counselor or therapist feels that his patient's interests can be furthered by his taking a battery of psychodiagnostic tests, he will refer the patient to a clinical psychologist. The therapist's final decision as to what would be best for the patient will take into account the picture presented to him in the battery of tests administered by the psychologist.

What are some of the various psychological tests? What names are associated with them?

Psychological tests are so numerous that only a few of the better known ones can be mentioned. They are divided here into several groups representing somewhat different fields of psychological investigation.

- 1—The Stanford-Binet and Wechsler-Bellevue intelligence scales, for example, are concerned with the individual's overall intelligence, with considerable emphasis on his verbal ability. (Alfred Binet, Lewis M. Terman, David Wechsler)

- 2—The Porteus Maze and the Healy Picture Completion (intelligence) tests, are examples of nonlinguistic or "performance" tests. They assess those aspects of intelligence which do not require the use of words. (Stanley D. Porteus, Rudolf Pintner, Donald G. Paterson, Florence L. Goodenough)
- 3—The Minnesota Multiphasic Personality Inventory and the Bernreuter Scale consist of questions which an individual answers about himself, attempting to give a picture in terms of his likes and dislikes, hopes and fears, disturbing psychological experiences, and so on. (Robert G. Bernreuter, Starke R. Hathaway and J. Charnley McKinley, L. L. Thurstone)
- 4—The Strong and the Kuder (vocational preference and interest) tests are somewhat comparable in method to the above, in that the individual answers questions about himself. In these, however, emphasis is placed on what interests him most. (G. Frederic Kuder, Edward K. Strong, Jr.)
- 5—The Rorschach, the Thematic Apperception Test, the sentence completion and freehand drawing tests have become known as *projective techniques*. In this group of tests, the information which the subject gives about himself is given unwittingly or indirectly. He may look at a series of meaningless inkblots and say what they look like to him. He may tell a story about what he thinks is happening to the characters in a series of pictures involving people in somewhat indeterminate actions. To the experienced psychologist, these stories reveal facts about the storyteller himself. They show his characteristic ways of thinking and feeling, and some of his own tensions, of which he need not be explicitly aware. (Hermann Rorschach, Henry A. Murray, Lawrence K. Frank)

What is clinical psychology?

The word "clinical" is used in this connection to indicate that the psychologist's concern is with some one person's specific problems, rather than with the general or universal laws of behavior, which is the province of academic psychology or psychology as a science. The word "clinical" is taken over from medicine, where distinction is made between work in the clinic or hospital, and work in research laboratories. Thus, in psychology, the clinical psychologist is one who attends to the person's problems or symptoms and attempts to alleviate them, rather than working in a university library or laboratory where he would be

concerned with more theoretical aspects. The clinical psychologist, for example, is more interested in the problems that are posed for Mr. Jones by his attacks of anxiety, than he is in the study of the general problem of anxiety itself. He is more concerned with the fact that Tommy is having difficulty in reading, and in trying to have Tommy overcome it, than with the nature of reading difficulties per se. Of course, this does not mean that from the study of any one individual case insights may not be derived, which throw light on the meaning of such symptoms and difficulties, or that the clinical psychologist may not be intensely interested in the theoretical problems. When he offers his services to the public, however, as a clinical psychologist, he is offering help to the troubled individual.

What does the training of clinical psychologists entail?

Before a clinical psychologist can offer his services to the public and administer tests in his own office as a private practitioner, he must have reached a high level of professional competence and have had considerable training and experience. He must have obtained a Ph.D. degree in psychology—that is, he must hold the highest academic degree that is available. This means that he must have spent not only four years in college, but must have studied and done research toward an advanced degree for another three or four years. In addition to this, he must have been apprenticed or have served an internship in some hospital or clinic, where his work with patients was supervised by more experienced staff members. In those states of the union that require certification, he will have to show several years of such supervised experience before being permitted even to take the state examinations for certification.

What persons seek a clinical psychologist's services?

Among those seeking the services of a clinical psychologist are educators, business and industrial administrators, lawyers, psychiatrists, and physicians. These people may need to know more about a person with whom they are concerned within their own professional sphere, and there are certain kinds of questions which psychological tests can help to answer. The educator, for example, may ask, "Is this child living up to his capacity in his schoolwork?"; the lawyer, "Has my client's memory been affected by the head injury he received in a car accident?"; the physician, "Is this patient emotionally well enough to be treated outside a hospital?"

Sometimes an individual may feel that he would like to take psycho-

logical tests to understand himself better, or to get help in some special problem he is facing. While there are ample opportunities to take tests where vocational guidance is sought, the services of the clinical psychologist are rarely utilized in this way. (See *Aptitude and Vocational Testing*) The reason for this is that the facts that come to light about a person, after he has taken the projective tests, can rarely be helpful to the individual if they are explained to him directly. They are best utilized if they are studied and interpreted by a psychiatrist or psychotherapist who has taken on the responsibility of helping the individual solve his emotional problems. Perhaps this can be best understood by an analogy. If a person falls and thinks his arm is broken, he does not go to a hospital and ask that an X-ray picture be taken. He goes to his physician who takes an X-ray picture. Thus, the findings of psychological tests, which may be likened to an emotional X-ray picture, cannot just be handed back to the individual as if that were the end of the matter. Clinical psychologists, therefore, usually work in conjunction with physicians or psychotherapists, marriage counselors or vocational guidance counselors, who will refer persons for psychological testing when they need information on some facet of an individual's life, of which the individual himself may be quite unaware. The clinical psychologist's report is a highly technical one that does not make sense to the layman; it should go directly to the source of the referral.

Is there any particular age-group better served than others?

Probably schoolchildren, adolescents, and college students are the age-groups most frequently tested. The average adult is not likely to be involved in situations that require psychological testing. Children and adolescents, while still in school, may be tested to see whether or not they are learning and achieving at a level consistent with their intellectual endowments. College students, who turn to their student health department for assistance with physical or emotional problems, might be tested by a clinical psychologist for reasons we have described elsewhere, namely, to give additional information about a student's strengths and weaknesses to the therapist or counselor who may be working with him.

How early in life can psychodiagnostic tests be useful tools?

It is possible to test very young infants by special techniques, although they have relatively little in common with psychological tests at the adult level. Arnold Gesell developed tests that contain items for

infants as young as three to four months old. "Tests" at this age involve information on whether or not the child's eyes will follow something with which he had been playing that has dropped on the ground; whether or not he can pick up a small pellet between his thumb and index finger, using a pincerlike movement. It is expected, for instance, that infants twenty-eight weeks old will be able to take hold of a pellet in this way. The test involving the eyes searching for a lost object would be used anywhere from seven months on. Most investigators feel, however, that information derived at this early age does not have anywhere near the same validity as it does when a child is older. Goodenough considers that tests given between eighteen months and five years of age have some predictive value for later mental ability. Most psychologists feel that the ages between eight and fourteen are the optimal ones for assessing intelligence.

What is the attitude of the community toward psychodiagnostic testing?

Americans, by and large, are "test minded" and have accepted intelligence tests as part of the educational system. If anything, they tend to be too impressed by the results of an I.Q. test. Testing of the personality traits, on the other hand, is likely to be looked at with greater suspicion, largely because it is a newer service psychologists can offer, and because, if not properly understood, it may appear as a somewhat threatening procedure. It is hard for some people to realize that the process of growing up emotionally is not a simple one, and that just as we accept, as a matter of course, the dentist's help in straightening out a child's teeth, so help from psychologists should be accepted as a matter of course in matters of straightening out emotional difficulties.

This help can be in the form of psychodiagnostic testing—that is, psychologists will supply additional and valuable information about a person's psychological resources and his psychological problems to a therapist who is attempting to help him. Help may also come in the form of some reeducational techniques as, for example, helping a child who is backward in reading to overcome this difficulty. Psychologists also provide the kind of help needed to straighten out marital difficulties. Some psychologists are fully trained analysts, who are equipped to provide long-term treatment for those whose problems require a rather basic change in their approach to life and ways of responding to the situations in which they find themselves.

Is this attitude changing from that of previous generations?

Yes. Gradually the unnecessary shame that has sometimes been attached to understanding oneself emotionally through psychological tests is vanishing. We are becoming much more aware, as a nation, of the importance of being psychologically healthy, and of not suffering from unnecessary psychological quirks that can make us unhappy. For instance, it is no longer necessary for the shy youngster to suffer agonies of embarrassment. He can be helped. Psychologists are becoming known as part of the mental health team in the community. They are part of the faculties in schools and colleges.

Are there any facilities for free or low-cost testing?

Very few, at the present time. Psychologists in private practice will almost invariably reduce their fees for individuals who are unable to pay the regular charges. They will also take a certain number of cases without any remuneration, if the referring physician requests it for special reasons. Exhaustive psychological tests are made on patients in state hospitals where, of course, no charge is made. But low-cost clinics for testing on an outpatient basis are very rare.

Is there sometimes resistance to involvement in psychodiagnostic testing from the individual?

Yes. Occasionally the individual to be tested may feel unduly threatened by the testing procedure, or by what the tests may reveal. The well-trained psychologist, however, is usually able to explain to the individual that the results obtained from the test material will give insight into the individual's problems. It is also the responsibility of the trained psychologist to establish rapport and to set the patient at ease so that his apprehensions will subside.

Is there sometimes resistance to involvement in psychodiagnostic testing from the family?

Yes, on occasion. Just as the patient may be apprehensive, so parents may fear that tests might bring to light facets of a child's problems which they may be unwilling to accept. Much depends on the confidence the psychologist can inspire and on the way he can explain why the tests are needed, and how the family physician or psychiatrist may be better able to help the child once the test results are available to him.

How may psychodiagnostic testing be satisfying or rewarding to the individual?

The results of psychodiagnostic tests are frequently used by counselors and psychotherapists as part of the general program of self-understanding, toward which any good psychotherapy is directed. Some psychologists specialize in using the individual's own answers from the test to demonstrate his psychological strengths and weaknesses. Psychodiagnostic tests are sometimes used as measuring rods of increased maturity or emotional development. A very satisfying and rewarding experience for the patient is to have his test findings (administered prior to some form of self-understanding) compared with the test findings taken subsequent to his psychological treatment. The growth in himself, which he may have experienced, can be demonstrated to him in an objective fashion through the altered test findings.

Can test results deliberately be faked by the individual being tested?

To some extent, yes; and with some tests, yes; although, interestingly enough, it is very rare that an individual, when actually participating in the test situation, can carry through consistent faking. Theoretically, however, it would be possible to pretend not to know the answers to information or other questions in a deliberate attempt to lower one's score. It is also possible, in personality inventories or questionnaires, to answer certain questions untruthfully. However, in the majority of tests used in clinical situations, particularly such tests as the Rorschach inkblot test, it is impossible for the individual to fake deliberately, since he is unaware of what constitutes a good or a bad answer.

Can a Rorschach test be interpreted without other information about the subject?

It is necessary to know the age and the sex of the subject before a Rorschach test can be interpreted. This would be considered indispensable for the simple reason that some answers, perfectly acceptable at some age levels, may indicate a disturbance at others. In the same way, answers given by a male subject might be misinterpreted if it were assumed that the subject was a woman. Outside of this, however, it is not necessary to know anything more about the subject, although it is extremely helpful to know for what reason he or she has been referred for testing. A lot of time can be saved, and a report can be made much more useful and pertinent, if the psychologist knows

exactly what it is that the referring physician or psychiatrist would like to know. The best clinical psychologists, although they are capable of writing reports on what is called a "blind" basis (that is, knowing nothing whatsoever about the subject), prefer to relate their report to the unanswered questions in the referent's mind.

Can results be misinterpreted by a trained tester?

It is doubtful whether test results can ever actually be misinterpreted by the trained tester, if by misinterpreted we mean a wholly wrong conclusion being reached or misleading information given. Misleading information, for example, would be the underestimating of the gravity of a person's emotional problems or, conversely, overestimating them in a relatively healthy personality. There are certain danger signals in the tests that all psychologists will recognize, which indicate that the individual tested is in need of immediate psychiatric or psychological help. All trained testers will recognize such signs. On the other hand, reports from two psychologists, both well trained, will never be identical. One specialist may, perhaps, put more emphasis on one aspect of an individual's problems as it appears in the test, and one on another. They may each write their report on the patient from a slightly different angle. Occasionally, just as in physical illness, two physicians may give a slightly different interpretation of the patient's condition, depending on the weight each places on certain symptoms. The fact that the patient is either gravely ill or in relatively good health will, of course, be apparent to both of them.

How is psychodiagnostic testing used in business and industry?

Tests, in business and industry, are used primarily for selecting candidates to fill job openings. (See *Aptitude and Vocational Testing*)

Occasionally, however, an employee may have an emotional problem that lowers his efficiency, causing excessive fatigue, or resulting in illness and absenteeism. If the psychologist working in the industrial concern has also had clinical training, he may administer a battery of psychodiagnostic tests, with a view to suggesting the proper type of counseling for the individual in question.

Are psychodiagnostic tests used in marriage counseling?

Yes, and particularly when the marriage counselor is also a clinical psychologist, a combination which is not at all rare. The psychologist then, in his role of counselor, obtains valuable information and under-

stands his clients much better through seeing them, not only in the interview situation, but also seeing them in terms of the "emotional X-ray pictures" which the test provides. When couples are tested in this way very valuable information frequently comes to light, for the tests may reflect certain deep incompatibilities which must be brought to light before there can be successful counseling. Often the reasons given by the marital partners for their difficulties turn out to be relatively superficial ones when contrasted with those that come to light through the testing, which reaches deeper layers of personality.

Are personality tests accurate?

No human instrument is perfect and no method is ever completely successful. Nonetheless, in the vast majority of psychodiagnostic examinations done by trained psychologists, the quality and severity of the emotional disorder will be manifest in the test findings, and will be reported on by the psychologist. The fact that nearly all state hospitals, many general hospitals, and clinics have psychologists on their regular staff points to the fact that this method of examination has become a typical part of dealing professionally with emotional and psychological disturbances.

Can testing show that a physical disorder might have an emotional origin?

Some physical symptoms—known as *psychosomatic* disorders—actually have an emotional origin; for example, a headache that is due to psychological tension, or vomiting and nausea which may be directly related to some anxiety. Psychodiagnostic tests are extremely helpful in indicating when there is an emotional basis for such physical symptoms. Tests, such as the Rorschach, may bring to light conflicts and tensions of which the patient himself may be unaware, but which are taking their toll in physical, rather than psychological, distress.

Can test results be abused?

It is unlikely that the adequately trained psychologist would permit abuse of the test results. He must be on his guard, however, to refrain from exaggerating their infallibility or importance. Test results should always be considered as only one of several ways in which the individual can be understood and helped. There is nothing magical about testing, and certainly it cannot always have the answer to all questions.

How has the cumulative knowledge of psychodiagnostic testing affected the medical field?

The general practitioner is probably not yet fully aware of the implications of psychological testing for individuals with physical complaints. This is one of the most challenging and as yet undeveloped fields for the psychologist. The very fact that an individual is ill naturally evokes anxiety. Psychological reports on patients with physical illness in acute phases or with chronic diseases can be helpful to the physician in the care of that particular patient. It is one of the responsibilities of psychologists of the present day to demonstrate the usefulness of psychological testing to the average general practitioner.

What is the attitude of psychiatry toward psychodiagnostic testing?

The psychiatrist and the clinical psychologist work closely together. The psychiatrist uses material from the psychological tests to extend his knowledge of his patients' problems and in many instances to derive information from them, which might otherwise have taken him considerably more time to acquire. Sometimes the psychiatrist will want to have his own opinion confirmed as to the seriousness of an individual's emotional problem, for example, from a completely independent source, such as from a specialist using techniques different from his own.

Have psychodiagnostic tests been used successfully in mental hospitals?

Yes. In recent years much has been done to speed the progress toward recovery of the individual in a mental hospital. Psychodiagnostic testing—tests such as the Rorschach, the Thematic Apperception Test (T.A.T.)—may be used to help in determining the method of treatment, the patient's availability to help, the likelihood of his responding well to individual or group therapy, and finally to act as a measuring rod in determining the extent of his recovery, and his preparedness to return to full activity outside the hospital.

Are the methods used for the mentally ill different from those used otherwise?

Essentially, no, although it may sometimes be necessary for the psychologist to allow more time for the testing of individuals who are experiencing acute psychological distress. The psychological tests in use today give valuable information both on the psychologically disturbed and on those who are functioning normally.

PSYCHOLOGY

by DAVID SHAKOW, P.H.D.

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What is psychology?

Psychology has been defined in a number of ways. Briefly, it may be described as the general study of human and animal behavior. More comprehensively, it is the branch of science that deals with behavior or mental processes, and with the mind, self, or organism which behaves or has the mental processes.

Psychology has such intimate relationships with both biology and sociology that it must be viewed in conjunction with them as well as independently. The relation with biology grows out of the fact that psychological processes and psychological development take place in a body which is undergoing parallel physical processes. The relation with sociology stems from the occurrence of the psychological processes in a social context.

What are psychology's aims?

Its aims are to study behavior empirically and systematically, and from such study to build up a body of principles for explaining, predicting, and modifying behavior.

What are psychology's general principles?

The basic principle of psychology as a science is that behavior—whether in human or animal—can be approached in the same general way as are any other natural phenomena studied by other areas of science. This principle holds that even in the case of man, in whom behavior is exceedingly more complex than in other animals, it is possible to collect data that lead to conclusions which permit understanding and prediction. Psychology, as Clyde Kluckhohn and Henry A. Murray have pointed out, holds that “every man is in certain respects (a) like all other men, (b) like some other men, and (c) like no other man.” But even with respect to the last of these—the individual characteristics of a man—psychology holds that it is possible to use the scientific method. In this case the observations can, of course, lead to generalizations and predictions only about the particular person.

What are the major phenomena with which psychology deals?

Psychology deals with the manifestations of "mind" and behavior, whether it be in animal or human, child or adult, aberrant or normal. Traditionally the three major categories of mental processes have been thought of as cognition (knowing), affect (feeling), and conation (willing). But more specifically, the phenomena dealt with by psychology fall into many areas such as the following: vision, hearing, and other senses; attention and perception; language and speech; learning and remembering; imagination and thinking; motivation; feeling and emotion; frustration and conflict; intellectual abilities; personality; attitudes and beliefs; aptitudes and vocational adjustment; work and efficiency; prejudice and social conflict. In addition, psychology is concerned with such problems as maturation and development of psychological functions, and the effects of social influence on psychological functions.

How does psychology deal with these phenomena?

To deal with these phenomena or areas of concern psychology uses four major approaches: the experimental, the psychometric (testing), the clinical, and the survey. Each of these has both its advantages and limitations, its special appropriatenesses and inappropriatenesses. The *experimental* method brings problems into the laboratory and, especially with animal subjects, provides control of sample and conditions, limitation of the variables, and the possibility of repetition under closely similar conditions. In psychological science the experimental method, though highly important, is not so widely useful as in the physical and biological sciences, since so many phenomena are difficult to place under laboratory conditions and since the laboratory situation, including experimental control, may modify the very phenomenon one wishes to study. Other methods must therefore be called upon. The *psychometric* method is a modification of the experimental. It uses standardized devices (tests) in a standardized and relatively natural situation, interpreting the data obtained from each subject by standardized norms, rather than by comparison with the performance of a special control group. This procedure is designed to call forth a representative sample of the subject's behavior. Ordinarily it deals with more complex phenomena than does the experimental approach, and is utilized without the elaborate attempts at control that experiment calls for. The *clinical* method is less standardized and controlled than either of the above two. It has the advantage, however, of dealing with situations and phenomena in a relatively naturalistic manner. The

freedom in approach it offers carries with it the handicaps of accumulating a great deal of complex data which need analysis, and also introduces a much greater possibility for subjective bias. The *survey* method approaches a problem with a number of definite questions which are taken into the field to the persons who are the subjects of the study. This method ordinarily depends on scientific sampling methods for its choice of subjects, and carefully planned methods of questioning in order to avoid bias in the interpretation of the findings. All these approaches have been used and continue to be useful in the mental health field.

What is psychology's history?

Hermann Ebbinghaus said, "Psychology has a long past but only a short history." Through most of its long past, psychology was closely intertwined with philosophy. Scientific psychology, with whose history we are particularly concerned, grew mainly out of English empirical philosophy (Francis Bacon, Thomas Hobbes, John Locke, George Berkeley, David Hume, John S. Mill, and others) and the psychophysiology of the early nineteenth century (Charles Bell, François Magendie, Johannes Müller, Hermann Helmholtz, and others). As a scientific field, psychology is a little over one hundred years old. Its first formal experimental laboratory was founded in 1879 (at Leipzig by W. Wundt), although William James had earlier had an informal psychological laboratory at Harvard.

The men most prominent in the field might be introduced by listing the four men whom E. G. Boring, the major historian of psychology, considers as the "greats" of psychology: Charles Darwin, whose theory of evolution was one of the great revolutions in human thought, who stimulated the genetic approach in psychology, and contributed importantly to the understanding of emotions in man and animal; Hermann Helmholtz, whose major studies of hearing and sight and of electrical conduction in nerves laid much of the foundation for experimental psychology; William James, who developed a new theory of emotion and who contributed importantly to psychology's development by writing what is probably the most famous and influential textbook of all time, *The Principles of Psychology*, a book that is still having its impact though seventy years old; and Sigmund Freud, the originator of psychoanalysis, who, by uncovering the complex motivational side of man, fathered another great revolution in man's perception of himself.

Aside from these four, the men most prominent in the history of psychology of the last one hundred years may best be presented by the country in which they had their major careers. They are (1) Germanic countries: G. T. Fechner, W. Wundt, H. Ebbinghaus, Franz Brentano, C. Jung; (2) England: Sir Francis Galton, Charles Spearman, William McDougall; (3) France: Alfred Binet, Pierre Janet; (4) Russia: Ivan Pavlov, V. M. Bechterev; (5) United States: G. S. Hall, R. B. Cattell, J. B. Watson, Clark Hull, Edward L. Thorndike, E. B. Titchener, Kurt Lewin, Wolfgang Köhler, R. S. Woodworth.

What are the different schools of thought in psychology?

About a generation ago "schools" of thought were much more prominent than they are at the present time. The structural, the Gestalt, the behavioristic, the hormic, the psychoanalytic, and the personalistic, and other schools vied with each other for attention and argued that their own views provided the only true basis for psychology. The major research findings of these schools have now been incorporated into the body of psychology, and particular aspects of their points of view have left their effects on the general framework of present-day psychological theory. Although different points of view still exist, there is relatively little concern today about schools. Rather, the differing views are now presented as different *formulations* of psychological approaches and findings, formulations which do not contraindicate the possibility of other formulations. For example, we have different formulations in the field of learning: some emphasize stimulus and response reinforcement (Clark Hull, Neal Miller); some emphasize purposiveness (Edward Tolman); some emphasize the dynamic field (Kurt Lewin); some emphasize contiguity (E. R. Guthrie); some emphasize instrumental behavior (B. F. Skinner). In the same way in the field of personality, there are many different formulations, among which are: the psychoanalytic (Freud); the self-theory (Carl Rogers); the factor theories (Raymond Cattell, Hans Eysenck); personology (Henry A. Murray); and field theory (Kurt Lewin).

What purpose do different formulations and schools serve?

There is a popular impression that scientists are entirely objective and rational, that they coldly and carefully examine the evidence on all sides, and then arrive at a balanced conclusion. In actuality, science advances by the competition and conflict among scientists who hold strongly, and rather emotionally, both to their own points of view and

to the theories which they offer to account for empirical findings. In psychology, where the phenomena are so complex and so wide in scope, and where personal involvement is perhaps more difficult to avoid than in other fields, it is understandable that there are many points of view and many theories to account for similar findings.

During certain periods in the history of psychology, persons holding separate theories and interests formed "schools" which tended to emphasize the emotional involvement even more. Taken in the context of the longtime historical development of a field, such events are not necessarily to be deplored, for they lead to the need for clearer exposition of the schools' theories and for more critical examination of them, with resultant advantage for psychology as a whole. In the present historical phase of psychology, there appears less need for such strong identification; hence the schools have essentially disappeared.

Is psychology a science?

Doubts about the scientific nature of psychology stem from a variety of sources. Contributing to these doubts are misconceptions about the nature and range of science, the perception of psychology as being limited to the area where it borders on philosophy, and a misinterpretation of the fact that psychology has—because of its subject matter—greater difficulty than other fields in achieving measurement and control.

Psychology is a science, for it meets the primary criteria of a science: (1) it is founded on collected facts or data, rather than on argument or opinion; (2) it is systematic—the facts are collected according to plan; (3) it classifies these facts; and (4) it develops generalizations from these classifications in the form of hypotheses or theories for further testing.

How does a psychologist differ from a psychiatrist?

The confusion between these professions arises essentially in the clinical or therapeutic area where their respective functions overlap. Although both professions devote themselves to problems that are fundamentally psychological, and there does exist an overlap in function, there are distinct differences in training background and in respective range of function.

The psychiatrist is a physician with a medical degree and a period of general medical internship. After meeting the requirements of State Board licensure, he is officially qualified to practice any branch of medicine. However, in line with the growing practice of specialized

medical training, he goes through an approved psychiatric training program involving at least three years in a psychiatric training center. If he wishes to meet the standard requirements for board certification (American Board of Psychiatry), he must have at least two more years of practice and pass an oral examination before a board of experts. He is then recognized as a specialist in psychiatry, one who is competent to deal with the wide range of aberrant cases from mild neurosis to extreme psychosis, including cases having psychosomatic illness.

The psychologist's background is much less standard, as it varies according to his area of specialty. In all areas of psychology the Ph.D. degree is required for full professional qualification. To this are added the special requirements set by the particular specialty. In the areas identified with fieldwork and practice there is a tendency to set more definite requirements than in areas associated with a university.

As we have said, the clinical psychologist is most closely identified with mental health and works in an area which overlaps most with that of the psychiatrist. Typically, he has a Ph.D. in clinical psychology from a university whose training program is approved by the American Psychological Association. The program requirements consist of at least three years' study in basic and clinical psychology, a research project and a dissertation, and a year's internship in a clinical setting.

Several steps follow the Ph.D. if he wishes to meet the local and national requirements which the profession is increasingly demanding. The first of these is to obtain a state certificate or license. (As of December 1961, seventeen states and the Province of Ontario had laws governing the use of the title of "psychologist" and the practice of psychology. Although the requirements vary from state to state, typically the granting of the certificate calls for at least two years of acceptable experience beyond the Ph.D., or five years' experience for those without the Ph.D.) A next step is board certification by the American Board of Examiners in Professional Psychology (A.B.E.P.P.). This certification is under the control of the profession. In order to obtain the clinical diploma awarded by the board, the candidate must have his Ph.D. in clinical psychology and five years of superior performance in professional experience, four years of which must be postdoctoral. He must also pass both the written and oral examinations of the board. Similar diplomas are given in counseling psychology and industrial psychology. In contrast, in the areas most closely identified with a university, such as physiological psychology, comparative psychology,

learning psychology, social psychology, and personality psychology, little is set in the way of formal requirements aside from the Ph.D.

Because of the great need for personnel in the applications of psychology, increasing emphasis is being placed upon the development of competently trained persons at the M.A. level to serve as assistants to the more fully trained. Two classes of trained psychologists not having the Ph.D. will then be practicing: (1) those just described, who will ordinarily be working under the supervision of a Ph.D. trained psychologist; and (2) a small group of persons who learned their psychology in the days before clinical psychological training had achieved an organized status. Although these persons did not obtain a Ph.D. degree in the specialty, they generally have had many years of experience to compensate for this. If such psychologists have the diploma of the A.B.E.P.P. (American Board of Examiners in Professional Psychology), they are considered equal in status to those having the Ph.D. degree.

How many psychologists are there in the United States?

To answer this question we must define the psychologist somewhat more narrowly than we have earlier defined psychology itself. If we consider the psychologists of this country to be those who hold membership in the American Psychological Association (A.P.A.), then there are about 20,000 psychologists. Kenneth Clark, in the course of a study for the A.P.A., has, on the basis of various samples, estimated that for every two psychologists who are members of the A.P.A., there are three also employed in psychological work who are not members. Most of the latter fall below the average background level of members of the association, but many of them do at least meet the minimum requirements set by the American Psychological Association for membership. If we accept this group as well, then there are about 50,000 persons in this country engaged in work that is broadly psychological. (Persons from other clearly defined fields such as psychiatry, social work, and education, are not, of course, here included.) One-half to two-thirds of this total group are doing work related to the field of mental health.

Is the present number adequate?

There is little doubt about the present numerical inadequacy of personnel in this field, considering the number of available positions that are being left unfilled. George Albee, who has made a special study of mental health manpower needs for the Joint Commission on Mental Illness and Health, estimates that existing needs in the field could easily absorb an additional 10,000 psychologists.

Do the number of psychologists differ in other countries? If so, why?

The number of psychologists are proportionately fewer in other countries as compared with the number in the United States. If we accept the membership of the American Psychological Association as the measure, then there is about one psychologist to every 10,000 of the population. The best comparable figures (derived from the *1957 International Directory of Psychologists*) are: United Kingdom, one to 65,000; France, one to 100,000; Germany, one to 50,000; Switzerland, one to 30,000; Scandinavia (Sweden, Denmark, Norway), one to 30,000; U.S.S.R., one to 810,000; and Japan, one to 120,000.

One can only guess as to the reasons for the differences in favor of the United States. In part they lie in the greater interest in the field of psychology in this country. This probably stems partially from the relatively high standard of living which permits the culture to indulge itself in concern with its thoughts and feelings. Where bare physical needs of a society are largely unmet, energies are necessarily channeled in the direction of these minimum satisfactions. Since there is also a greater degree of organization of psychology in the United States, more persons practicing psychology are known as "psychologists," which helps to swell the number. In other countries persons carrying out similar work may practice psychology in their capacities as physicians, nurses, educators, or as members of a number of other professions. This is particularly true in such countries as the U.S.S.R. There is, however, an increasing interest in the behavioral sciences all over the world, particularly in the European countries, and an increasing trend to designate such persons as psychologists.

Where and for whom do psychologists work?

The data compiled by the National Scientific Register (1956) show the places of employment of psychologists to be as follows:

| | Percentage |
|---|------------|
| Universities and colleges | 40 |
| Schools (public and private below college level) | 9 |
| Industry and business | 7 |
| State and local government | 12 |
| Federal civil service and armed forces | 17 |
| Social agencies (nonprofit) | 3 |
| Private hospitals and clinics—nonprofit foundations | 6 |
| Self-employed | 4 |

What are the salary levels?

Salary levels for psychologists in the United States vary considerably, depending upon place of work, geographical area, and specialty. In general, industrial salaries and private practice incomes are highest (ranging in the neighborhood of from \$10,000 to \$20,000), leading university and civil service salaries are next in order (\$7,500 to \$18,000), and smaller college and most state institution salaries, the lowest (\$5,000 to \$8,000). The salary level in the federal service for a recent Ph.D. in clinical psychology is about \$9,000 (GS-11 and GS-12). The ordinary range extends to about \$15,000 (GS-15), although there are higher grade positions that pay higher salaries. The salary level is dependent, of course, upon the experience of the psychologist and the administrative responsibilities connected with the position.

What are the various functions of the psychologist?

The answer to this question depends both on the kind of psychologist one is talking about, and the place where he is working.

The psychologist who is most closely associated with the mental health field is the clinical psychologist. When he is employed in a clinic he ordinarily carries out two major functions: psychodiagnosis and therapy. In other settings he may have the additional functions of teaching and research. This is especially likely if he is employed in a medical school or university.

There are many other kinds of psychologists and many other settings in which psychologists work. The American Psychological Association consists of twenty-two divisions, each of which represents an activity or interest area. A listing of these divisions will give some notion of the range of psychology and the functions of psychologists. The divisions are: general psychology, teaching, experimental, evaluation and measurement, developmental, personality and social, social issues, esthetics, clinical, consulting, industrial and business, education, school, counseling, public service, military, maturity and old age, engineering, and psychological aspects of disability. There is a tendency for psychologists in these divisions to concentrate in certain institutions—the kind of institution is frequently clear from the designation. Persons in any of these divisions may, of course, be associated with a university in a teaching capacity, or located in institutions quite different from that which the class designation would lead one to expect. In any case, if one is interested in the services of a psychologist it is important to know what his area of specialization is.

What are the attitudes toward psychologists as therapists?

It is difficult to make a generalization about this topic because there are contrary trends at work. Based on the composite evaluations obtained from a group of psychologists with considerable experience, evidence for two different attitudes exists. On the one hand, many—perhaps most—physicians take the attitude that any form of therapy is exclusively a medical activity. Frequently they treat the patient themselves. If they do not do so, they tend to limit psychotherapy to psychiatrists to whom they refer their cases. On the other hand, a considerable number of physicians—the usual examples given are pediatricians and internists—practice otherwise. They may find that carrying a case in association with a psychiatrist, who is actually another physician, raises some difficulties for them, and they therefore prefer to associate themselves with a person in a different profession, in this case a competent psychologist.

A study conducted by Jum C. Nunnally indicates that general practitioners refer somewhat over 50 per cent of their mentally disordered cases. By far the predominant referral is to psychiatrists, with 55 per cent of the group stating that they never refer patients to psychologists. Nevertheless, 3 per cent reported doing so “often,” and 34 per cent, “sometimes.”

In general, little question is raised among psychiatrists about psychotherapeutic work by psychologists when this is carried out in institutional settings, where at least nominal medical supervision is available. Much more question has been raised about such practice when it is independent and private. There is, however, growing acceptance by psychiatrists of psychologists doing private practice when it is conducted with proper medical safeguards for the patient or client.

The changing attitude is due to a variety of factors. These include: increasing recognition of the psychotherapeutic manpower shortage; increasing control of the quality of private psychological practitioners both by the profession and by the individual states; and increasing doubt that much of psychotherapy is necessarily a medical activity. This increasingly “accepting” attitude is evidenced in the growing referral of cases by psychiatrists to competent clinical psychologists. It is also reflected in the book, *Action for Mental Health*, the final recommendations of the Joint Commission on Mental Illness and Health. (See *Psychotherapy*)

Nunnally's previously cited study, although limited in scope, gives some information on the attitude of the layman. He found that lay-

men stated that they most often consulted psychiatrists in the event of mental illness in a family member. Nevertheless, a considerable number indicated the selection of a psychologist in preference to a general medical doctor or other persons offering such services.

It would perhaps be fair to infer from the increasing use of psychologists in the private practice setting, as well as in clinics, that the lay public does recognize the psychologist increasingly as a psychotherapist. Whether this is due to the difficulty in obtaining psychiatric assistance, or to the gradual recognition that there are various professions which can offer competent help in this area, is difficult to say.

What have been the contributions of psychology as a science and as a profession?

It is most difficult to draw a distinction between psychology's contribution as a science and as a profession. The latter grows out of the former, and the applications of the science are what constitute the contributions of the profession. In some instances the contribution remains largely at the scientific level; in others, progress has been sufficient to extend the contribution to the professional level. The answer to this question will therefore deal with both simultaneously.

The contributions come from a wide variety of fields of psychology. Each has had its impact in different ways on a wide range of areas of social activity or on other branches of science. These contributions derive from studies originating in such diverse psychological fields as learning, perception, testing, development and decline of psychological functions, or therapy.

The contribution to the area of education is a major one. The educational process is primarily a learning process. To this central area educational psychology has contributed the knowledge of the various facets of learning. This has not been limited merely to delineating the "how" of learning. Psychology has also increased the understanding of the "when" and "who" of learning, that is, the knowledge of the conditions which are optimal for learning, and the individual differences in capacity for both general and specific learning. The latter has been accomplished largely through the development and use of psychological tests. Learning principles are applicable in all content areas, whether the subject be arithmetic or literature, and provide the essential data for any effective teaching operation. (See *Psychodiagnostic and Personality Testing*)

When the ordinary procedures in the teaching situation are in-

effective, school psychologists, to be distinguished from educational psychologists, are available to deal individually with the referred children. On the basis of a comprehensive study of the situation, which may include several interviews and a variety of tests, the school psychologist diagnoses the underlying difficulty. In many cases he will then deal therapeutically with the child, by means of remedial teaching or remedial therapy. In other cases, he will refer the child to the proper person for therapy.

Associated with schools and colleges predominantly, but also active in other institutions, are counseling psychologists who provide vocational and educational guidance for students and others who are in the process of selecting their occupation or their educational programs, or who need help for minor adjustment problems.

Medicine and psychiatry have been aided by psychology in a number of ways. A major contribution has been through the large number of intelligence and personality tests developed by psychology that are helpful in the psychological diagnosis of patients. Because of psychology's particular interest in normal persons and normal development, it has been able to contribute norms against which suspected aberrance can be evaluated. It has thus served as a conservative influence against a too widespread inclusion of persons in the abnormal category. Psychologists have further contributed substantially to the development of new psychotherapeutic techniques, to the study of the processes and effectiveness of psychotherapy, and to psychotherapeutic activity itself. (See *Intelligence Testing*)

For business and industry, psychology has provided selection and placement tests which have been helpful in overcoming and avoiding inefficiency and vocational misplacement. In addition, much work has been done on the factors contributing to the greatest efficiency and the maximum satisfaction of both employee and manager. This has included the study of such topics as the causes and prevention of fatigue, boredom, and dissatisfaction, and the design of machines for most effective use. Contributions have also been made to advertising, a field which is largely based on the psychological principles of attention, memory, and motivation. (See *Aptitude and Vocational Testing*)

In the military area, psychology has made special contributions in three areas of major importance: selection and placement, counseling, and human engineering. The tests worked out by psychologists have been a mainstay of manpower selection and placement in the military during both world wars. In World War I, some two million servicemen

were tested. In World War II, ten million men were given the A.G.C.T. (Army General Classification Test) as an aid to the classification of their abilities, aptitudes, trade proficiency, and technical knowledge. On the basis of these and related criteria, officer selections as well as placements in the great range of modern military occupations were made. Psychologists developed pilot-aptitude tests for air force selection which were highly successful. In association with psychiatrists, psychologists supplied counseling and therapy for those who developed personality or behavior problems in the military situation. The third area of contribution to the military, that of human engineering, had its greatest development during World War II and has since continued to grow rapidly. The complicated machines which were being employed called for psychological as well as physical design, if the instruments were to be used most effectively. A considerable number of psychologists devoted themselves to this area. Their work was so effective that in the postwar period, with the development of even more complex instruments, human engineering has become a major field for applied psychology.

Psychology's contributions to the area of early development and maturation have been considerable. In fact, the Arnold Gesell and Benjamin Spock books, based on many years of research on the processes of physical, mental, and social development in the infant, have become indispensable handbooks for young mothers. Considerable contribution has also been made to the other end of the scale of development—the understanding of the maintenance and decline of psychological function in old age.

There are many other areas of application—to law, to criminology, to the ministry, to social work, to engineering, and other fields—which we cannot take the space to develop here. In areas thus far not mentioned, many contributions have in recent years been made to understanding the basic aspects (affective, cognitive, and conative) of the relationship of the brain and other parts of the nervous system to behavior, and to the systematic understanding of the factors which go to make up personality.

How has everyday living changed because of the results of the study of psychology?

The effects of psychology on everyday living are widespread. Ernest Havemann wrote a popular book, *The Age of Psychology*, based on a series of articles in *Life* magazine. This characterization seems ap-

appropriate if psychology is defined broadly. It is difficult to go through a day without being faced with phenomena to which psychology has called our attention, or without being affected in one way or another by findings derived from psychological study. Some of the highlights of the many areas of contact with psychology may be illustrated by the following hypothetical account of a father's day.

At breakfast the husband may read a newspaper that has several daily columns giving advice on ways of handling psychological problems. As he glances through the paper he runs across advertisements, many of which have been deliberately laid out according to psychological principles of attention-getting and interest maintenance. On the way to work he may be guided through traffic by signs whose shape and color have been determined by psychological studies for their effectiveness in encouraging safe driving. The car he drives may have a panel whose dials and knobs have been placed according to human engineering principles. On the job he may sit in an office whose color scheme has been determined according to principles directed at achieving the greatest efficiency. The general conditions of work in his factory may be based on special studies designed to determine the optimal criteria for efficiency. He may be scheduled to take a series of psychological tests for possible promotion. And very likely, he had originally been selected for the job he holds by means of a series of such tests. He may come in contact with colleagues who are presumably suffering from aberrances of one kind or another—whether it be uncontrollable suspiciousness or excessive drinking, or any one or more of a multitude of other symptoms. Rather than merely dismiss them as “queer,” he is now able, from his reading, from watching television, and theatergoing, to recognize them as persons who need psychological help.

On his return home, his wife may tell him of the television serials she has managed to watch while the older children were at school and the baby asleep. These dramas have probably dealt with psychological problems, though they may not have been solved by the best psychological principles. What she does not report is the overdose of advertisements which were interlaced—the forms of which were probably determined by psychological findings. More important, she may tell him enthusiastically about the baby's new achievement, which, according to the Gesell book, the average child of the same age does not show for another month. Perhaps she tells him about the older daughter's report of having learned arithmetic in a quite new way today—through playing with a kind of slot machine. Unfortunately, she may also have to

report that the oldest boy has been referred to the school psychologist because of difficulties with reading.

Any person is constantly behaving and being exposed to the behavior of others. He is equally exposed in his daily life to situations and conditions which have been designed to meet or modify his needs and other psychological characteristics. Psychologists have carried out systematic studies in virtually all areas relating to daily living—some in the laboratory, others in the clinic and the field. However, because of the complexity of the problems themselves, the diversity among human beings, and the newness of the field, the knowledge thus far achieved, when compared with what still remains to be done, is not great. It is only through persistence in systematic attack that we can hope eventually to deal with the world's psychological problems in some degree more comparable to that which we have achieved in dealing with its physical problems.

What is the status of psychology and psychologists?

Psychology is a growing profession, actually growing relatively faster than any other major profession. The membership of the American Psychological Association has approximately doubled every seven or eight years since its founding in 1892. Recently, Kenneth Clark made a comparison of the 1950 membership in the American Psychological Association with the 1950 membership of fourteen other prominent national organizations representing such diverse fields as chemistry, psychiatry, social work, and history. He found that while the American Psychological Association had eighteen times as many members in 1950 as in 1920, the organization closest in degree of increase was the Federation of American Societies for Experimental Biology, which had increased 7.5 times. In terms of Ph.D.'s granted, psychology has risen from a rank of eleventh in 1941–1945 to fifth in 1951–1953.

This growth appears to reflect increasing social demands from a great variety of fields, but particularly from the area broadly defined as mental health. It is estimated that the American Psychological Association will have 40,000 members by 1970. The expectation is that at least half of these will be in fields associated with mental health.

If psychology maintains and improves its present standards of training for the mental health area, standards which call for an integration of basic theoretical and experimental with clinical approaches, the status as well as the membership of the group should grow. It must not only continue improving along the directions in which it has already

started its training, but it must in addition continue to support its practice with new findings from research and scholarship. Encouraging evidence for continuing concern with research is found in the fact that in the most recent review, over 50 per cent of the National Institute of Mental Health research grants were made to the field of psychology.

Aside from this combination of research with practice, psychology has the possibility for making another important contribution. Psychology, because of its place in the hierarchy of the sciences—a place between the natural sciences such as physiology, on the one hand, and the social sciences, such as sociology, on the other—is in a peculiarly strategic position from which to make an effective contribution as a bridge between these areas of science. It is for this reason that psychology must remain broad in range and maintain its contact with its near neighbors on either side.

PSYCHOPATH OR SOCIOPATH

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What is a psychopath?

Psychopath, or sociopath, is a label so variously defined and so loosely envisaged that it is often referred to as a "wastebasket diagnosis"—one resorted to for personality disturbances that do not neatly fit into other categories. The confusion surrounding the term is heightened by a tendency to apply it to almost any variety of irresponsible behavior short of full-blown psychosis. Many psychiatrists have found it a condition easier to recognize than to describe. However, a consensus perceives the psychopathic personality as that of an individual so defective in judgment and so lacking in control that he persists in aberrant, amoral, and often criminal behavior with little evidence of conscience or ethics and without ability to profit from experience, example, or precept. He is commonly a supreme egotist—parasitic, sadistic, heartless, craven, and eely, with infinite capacity for victimizing others, and with seeming indifference to the pain and loss he habitually inflicts, except for the cruel satisfaction he sometimes derives from his malignant ill-doing. He is a classic hypocrite, maintaining a mask of fraternal concern so long as his imposture succeeds, but projecting the blame on others and on circumstances when his acts bring on the collapse of his fraudulent façade. He fancies himself a superman, and is unshaken by exposure; his career is an endless alternation of gross transgressions and attempts to shrug off the consequences. Some of the less blatant psychopaths achieve a fair measure of impunity, but the usual course is admission to a mental hospital or, more likely, a prison.

Popularly described, the psychopath is a scoundrel, confidence man, flimflam artist, goldbrick dealer, or fortune hunter in the disguise of a much weathered "lonely heartier." In reality he is a person who shows a persistently malignant personality structure and a nonconformist who disregards social conventions and mores. His is probably the most colorful and protean among the array of psychiatric disorders. He either disclaims that there is anything wrong with him or boasts that he is invulnerable to the law because he has been diagnosed as a psychopath;

thus his delusion of virtual omnipotence. Actually he is an inveterate loser—he loses face, relationships, and status. Therefore, he is a perpetual wanderer seeking new and unexplored territory. He may spend a great deal of time in and out of prisons, but it doesn't take him long to smooth out the wrinkles of prison life and, with his pseudocharm, to cast out his net for new victims.

Elements of this description can also be found in persons who never see the inside of a prison—members of any professional, business, economic or social group.

The psychopath is a parasite who lives on the individual members or collective groups of society. He drains his opportunities to the last drop. Disdaining legitimate work, he calls himself "smart" and looks down on the "suckers" who tediously attend to their daily chores. His cynical, remorseless attitude toward his victims is summed up in his refrain: "So what? They asked for it, didn't they?"

In many cases the psychopath needs support to maintain his false conception, and he may use alcohol to excess or become a drug addict. (See *Alcoholism; Narcotic Addiction*)

Although he gives the appearance of warmth, interest, compassion, and unselfishness, these aspects are superficial and short-lived, only serving the purpose of creating the proper milieu and time to effect the financial sting, or depart with his "beloved family's" jewels or bank account. He may sell bogus securities or promote dubious enterprises, soliciting partners for "the drilling of oil wells" or the "prospecting of uranium mines." He has all the equipment for persuasiveness and utilizes every instrument, e.g., photographs, movies, clippings, etc., to obtain his "client's" confidence.

His emotions are so superficial that he never manifests compassion for the victim's loss. He rationalizes with the remark that "there is larceny in everybody's heart," when he tries to promote a shady deal. Although he knows the difference between right and wrong, application of this principle as far as he is concerned is very remote or non-existent.

The psychopath always has been described as an "amoral personality." He is certainly amoral where his own acts are concerned, but should anyone steal from him (as may occur in prison life), he becomes outraged and will go to the utmost extent to penalize the perpetrator.

Some observers have felt that psychopaths are free of anxiety and guilt. Guilt certainly does not appear on the conscious level, and if it exists at all it is so deeply repressed that no evidence of it can be demon-

strated. Anxiety, on the other hand, is quite often manifested even on the conscious level, but in dream life and subconscious life it is always perceptible. It is mostly concerned with himself and practical questions, such as whether he can "beat the rap," whether he can create an impression that he is not really responsible, or whether he can transfer alibis for his acts to other persons or circumstances. Some authorities have considered that the psychopath is clearly aware of his fakery, and that his devil-may-care pose is a cover for depression.

Some authors would include sexual offenders in this group and classify them as "sexual psychopaths." This is unjustified, however, since the real sexual offenders only rarely show any other criminal act. Their deviation is confined to sexual customs and practices, and they are weighted down with some guilt and retrospective insight. The psychopath can commit sexual offenses, but that is just one of his many criminal activities. The sexual offender is a soloist, while the psychopath conducts an orchestration of criminal offenses. (See *Sexual Deviation; Sexual Psychopaths and the Law*)

In 1952 the American Psychiatric Association, in its *Diagnostic and Statistical Manual*, substituted the term "sociopathic personality disturbance" for the earlier designation "psychopathic personality." The manual states: "Individuals to be placed in this category are ill primarily in terms of society and of conformity with the prevailing cultural milieu, and not only in terms of personal discomfort and relations with other individuals. However, sociopathic reactions are very often symptomatic of severe underlying personality disorder, neurosis, or psychosis, or occur as the result of organic brain injury or disease." As subclassification the manual lists "antisocial reaction, dissocial reaction, sexual deviation, and addiction." However, the association's effort has not succeeded in displacing the older term "psychopath" because it is really a play on words, adding no new interpretation or usage.

The *Statistical Guide* of the New York State Department of Mental Hygiene presents this definition: "Psychopathic personalities are characterized largely by emotional immaturity or childishness with marked defects of judgment and without evidence of learning by experience. They are prone to impulsive reactions without consideration of others and to emotional instability with rapid swings from elation to depression, often apparently for trivial causes. Special features in individual psychopaths are prominent criminal traits, moral deficiency, vagabondage, and sexual perversions. Intelligence as shown by standard intel-

ligence tests may be normal or superior, but, on the other hand, not infrequently a borderline intelligence may be present."

Representative of the European viewpoint, L. Bovet, a Swiss forensic psychiatrist, includes this categorical definition in his monograph on juvenile delinquency, published by the World Health Organization: "Psychopathic traits are permanent character abnormalities, of constitutional origin, which are not derived either from psychoses, neuroses, or mental deficiency, and which predispose the psychopathic personality to behavioral disorders from which he suffers or causes society to suffer."

In this and other mental disturbances it is prudent to regard the deviation from normality as primarily one of degree rather than one of kind, especially in the absence of any demonstrable absolute norm. Bernard L. Diamond has observed that conventional morality breaks down in the absence of identification with the victim—the operative factor notable in the psychopathic personality. The widespread tendency to cheat on income taxes and other self-regulated public obligations and to profit from the error of a large store or corporation has been cited as a common form of everyday amorality. The collective hysteria of wartime, which blocks identification with any individual victim, is presented as another sanctioned parallel with the psychopathic pattern. Although contact with the psychopath evokes censorious disapproval on a moral and self-righteous plane, it is sensible to reflect that constitutional or environmental factors can magnify and accentuate to a pathological degree, in some people, conditions that may only be latent or minimal in the rest of us.

What is the history of psychopathic disorder?

History, folklore, and fable indicate that the psychopathic condition has always been observable in man. The Bible and other records of early experience offer numerous examples. Plato's description in *The Republic*, four centuries before Christ, of the nature of the tyrant, whose power enabled him to give free rein to his acquisitive, aggressive, and sexual drives, has been cited as a prototype of this pathology; and any number of specific tyrants down the centuries have personified the basic symptom of apparently remorseless amorality.

In 1835 J. C. Prichard of Bristol, England, in his *Treatise on Insanity*, presented the term "moral insanity"—"a form of mental derangement consisting in a morbid perversion of the feelings, affections, and active powers without any illusion or erroneous conviction im-

pressed upon the understanding: it sometimes coexists with an apparently unimpaired state of the intellectual faculties." The term "moral insanity" fell into disuse, but "moral imbecility" or "moral defective" was long in favor. In cases so labeled, Prichard asserted, "the moral and active principles of the mind are strongly perverted or depraved; the power of self-government is lost or greatly impaired and the individual is found to be incapable, not of talking or reasoning upon any subject proposed to him, but of conducting himself with decency and propriety in the business of life." Prichard acknowledged the influence of such predecessors as Philippe Pinel, Jean Esquirol, Etienne Georget, and Benjamin Rush.

The term "psychopathic inferiority" was introduced by J. A. L. Koch in 1888 with the implied aim of de-emphasizing the moral tone of the descriptive material up to that time. From then on the clinical perspective widened, and the implications of a psychopathic state became more apparent. However, Koch's suggestion that certain of the hysterias and obsessional states could be included as evidence of psychical inferiority opened a line of debate that has persisted ever since. Terms synonymous with psychopathic inferiority, such as defective delinquent, emotionally unstable, defective abnormal personality, constitutional inferiority, and neurotic, entered the lexicon as a consequence of Koch's contributions.

The American psychiatrist, Isaac Ray, in 1838 had helped to establish the much debated moral factor when he made a distinction between what he termed intellectual mania and moral mania. As partial moral mania, he mentioned the occurrence of the irresistible impulse to steal, the inordinate propensity to lie, the morbid activity of the sexual functions, the tendency to incendiarism and to destroy, as by murder and suicide. At the turn of the century, the pioneer English psychiatrist, Henry Maudsley, was still defending his retention of moral insanity as a justifiable category.

The early Italian criminologist, Cesare Lombroso, together with his followers, is credited with having fruitfully stimulated the study of a biological basis for aberrant behavior, although his theory of a specific somatic type of born criminal is generally rejected. The public testing of his idea of a constitutional delinquency was contemporaneous with the long debate over the viability of the classification, "constitutional psychopath." Lombroso and his followers, by fathering the study of the offending individual and his behavior apart from strict legalism, helped to bring about not only humanitarian reforms in penal laws and

penological practice, but also a growing awareness of psychiatry's role in the diagnosis and treatment of criminal tendencies.

Meanwhile, the German and Swiss "schools of psychiatry" carried forward the work of the pioneers, clarifying the comprehension of the psychopathic states and sharpening the diagnostic criteria. Emil Kraepelin and others distinguished between psychopathic personalities and constitutional psychopathic states. Among the former, Kraepelin included such types as the unstable, the morbid liar, the swindler, and the pseudoquerulents. He suggested a relationship between the psychopathic states and certain psychoneurotic and psychotic reaction types, a point that has been only sparsely developed by later investigators. (See *Neuroses*; *Psychoses*)

The American "school of psychiatry," with Adolf Meyer as a leading figure, from 1905 onward has tended to sharpen the clinical differentiations of so-called constitutional inferiorities, emphasizing their separateness from states of mental defect. Meyer especially opposed Koch's tendency to involve the psychopathic states with the purer types of hysteria and psychasthenia. (See *Hysteria*)

Among other clinical investigators whose work has contributed to this process of clarification are: H. W. Wright, C. P. Oberndorf, E. E. Southard and Mary C. Jarrett, William Healy, H. M. Adler, Bernard Glueck, Rollo May, G. E. Partridge, and Eugen Kahn. According to D. K. Henderson's assessment, a general unity of attitude prevailed among them, any differences relating more to detail than to principle. In Britain the diagnostic term "constitutional psychopathic inferiority" is used, presenting the controversial implication that the condition is a congenital one.

Is there a greater incidence of the disorder in either of the sexes or among particular groups?

Among psychopaths who are caught, or who are otherwise brought under treatment, there is a far greater incidence among males. This does not necessarily signify that the condition does not exist in comparable proportion among females. In the first place, there are no reliable statistics, and the presumably small proportion of the actual total of cases that are recorded consists of those brought to public or professional attention largely by chance or by the individual's careless or overconfident conduct.

Also, the discrepancy between known male and female cases is probably a result of society's protective attitude toward women. Many

offenses, especially those of a sexual nature, remain undiscovered or unprosecuted; for example, the known tendency among maids and baby-sitters to masturbate little boys to put them to sleep. Nursemaids, too, have been known to hold a baby in a flowing, unlighted gas oven for the same purpose. Should such offenses be committed by a male, his chance of going undetected would be far less, and he would quickly be charged with impairing the morals of a minor or with assault, carrying liability of an extended prison term.

Likewise, the absence of data makes it impossible even to surmise whether the psychopathic condition may prevail conspicuously among particular national, economic, or religious groups, or in urban as contrasted with rural populations.

How many psychopaths are there in the United States?

Lack of any universal statistical reporting procedure, together with the absence of uniform standards of diagnosis, makes it impossible to hazard even an educated guess. The only available indications are piecemeal and fragmentary figures adduced from the number of persons classified as psychopathic in certain groups and institutions at isolated times.

In 1952, the last year in which the "psychopathic personality" classification was in general use, first admissions to state mental hospitals included 1,717 such cases (1,460 men and 257 women) out of a total of 101,920 patients. In 1957, first admissions to all public hospitals for mental diseases included 17,964 (14,678 men and 3,286 women) under the altered classification "personality disorders" out of a total of 121,069 patients.

Census data for the fifteen-year period from 1943 to 1958 show an increase in hospitalized cases of psychopathic personality from 2,694 to 17,964, but the figures' pertinence is open to question in view of the variety of conditions and statistical procedures prevailing in the various counts.

Wartime records of the United States Selective Service and armed forces induction centers indicated that about 10 per cent of the men rejected suffered from grave mental or personality disorders or major abnormalities of mood, and that 29 per cent of these were diagnosed as psychopathic personalities.

From 1942 to mid-1945, there were 457,000 neuropsychiatric separations from the army, of which 320,000, or 70 per cent were by medical discharge and 137,000, or 30 per cent by nonmedical discharge. The

latter group included psychopathic personality among various classifications. In World War I, of about 72,000 neuropsychiatric cases returned to civilian life from the armed forces, 9 per cent were classified as psychopaths. Other data from the same period show that of 69,394 neuropsychiatric patients, 9 per cent were diagnosed as constitutional psychopathic states.

Some authorities consider that psychopaths constitute a large proportion of all criminals. Sheldon Glueck has placed the proportion at around 20 per cent. In 1952 William and Joan McCord estimated on the basis of typical figures that there were 16,600 adult imprisoned psychopaths, 3,000 juvenile delinquent psychopaths, and 24,000 hospitalized psychopaths. This indicated total of 43,600 took no account of the unknown number of psychopaths remaining outside the institutions concerned. (See *Crime and Mental Disorders; Correctional Institutions and Psychiatry*)

S. K. Weinberg has placed the proportion of psychopaths in hospital admissions at 2.6 per cent. Sheldon and Eleanor Glueck once estimated that 7 per cent of incarcerated juvenile delinquents were psychopathic. Walter Bromberg and George N. Thompson in 1937 reported 6.9 per cent cases of psychopathic personality among almost 10,000 patients examined. (See *Juvenile Delinquency*)

In a small sample study in Miami of a group of 160 offenders referred for psychiatric examination from a municipal court, 63 were found to be mentally incompetent by nature of psychopathy.

"Though the incidence of this disorder is at present impossible to establish statistically," Hervey M. Cleckley says, "I am willing to express the opinion that it is exceedingly high. It doesn't seem an exaggeration to estimate the number of people seriously disabled by the disorder still listed under this ambiguous term as greater than the number disabled by any recognized psychosis except schizophrenia."

Thus it may be seen that, until agreement is reached on uniform standards of diagnosis and until machinery is provided for reporting all cases that come under public or professional scrutiny, as, for example, is done in the compilation of crime reports, the actual extent of psychopathic disorders will remain in the realm of fluctuating uncertainty.

What are the characteristics of the psychopath?

In a physical sense, the psychopath ordinarily presents no uncommon earmarks to the casual observer, other than the gay or earnest

façade he uses to hoodwink his victim. The experienced observer of human types, however, will discern a furtive, evasive, subtly changeable facial expression and an ill-concealed restlessness and impulsivity. The surface aspect of friendly concern and eagerness to interest and please will be found in time to mask an egotistic design to dominate, maneuver, and persuade. The psychopath's nature cries out for the unusual and paradoxical, for excitement and undue advantage, and his manner and personal impact are shrewdly molded to achieve his fraudulent but self-justifying ends.

On the moral side, lack of, or deficiency in, conscience appears to account for the psychopath's obliviousness to ethical standards. With faint or faulty conscience, he simply seems to have failed to acquire those moral controls that keep most people within the acceptable social standard. Being without conscience, however, is the extreme condition; the degree of freedom from social concern or remorse may vary from case to case. (*See Morals, Values, and Mental Health*)

The psychoanalytic concept is that the disorder consists of an absence or faulty development of the superego, the psychical censor that normally inhibits asocial tendencies. Where the superego is weak or absent, a person behaves without regard for those restraints that the cultural heritage has imposed. Some children, by constitutional defect, may lack the capacity for acquiring the standards ordinarily inculcated by training. Or the parents themselves may be so constituted, or so remiss that they fail to imprint upon the child's emerging personality the capacity for observing social norms. Thus the child, from deleterious parental example, or as a result of traumata inflicted by tumultuous and unfavorable experiences, may grow up with a disabling deficit in the mechanism of communal conformity. In many cases the defect does not appear, or is not fully operative, until the tensions of adolescence aggravate it. (*See Adolescence*)

Adolf Meyer long ago described the psychopathic condition as an early ingrained inability to conform to the consensus, and recorded these stigmata: poor emotional control, temper tantrums, moroseness, grouchiness, self-assertiveness, undependability, indecision, impulsivity, and querulous, callous, undisciplined, and egotropic behavior.

In business and industry it has been found that psychopathic personalities are hard to get along with and are dangerous to the morale and efficiency of the group. They are hard to detect, especially in places of authority, for on the surface some appear cooperative and are past masters in the art of making plausible explanations. Those in sub-

ordinate positions are described as querulous, unruly, undisciplined, malicious, and antisocial. They often quarrel with foremen and an occasional one has been known to damage property in revenge for criticism, or for excitement.

Winfred Overholser points out that there is far more to the psychopath than antisocial conduct and that there are psychopaths who succeed in avoiding conflict with the law.

"The psychopath in general," he finds, "may be said to be an impulsive individual who exhibits diffuse, unpatterned behavior. He usually has a history of having been deeply rejected in childhood and seems to be attempting to obtain attention by his aggressiveness. He has, however, apparently very little inner conflict and certainly has a warped capacity for love. His emotional relations are meager and his conscience is relatively underdeveloped. Thus we have a substantial group of symptoms over and above the possible antisocial behavior. There are grave disturbances in the patient's affective life, as well as in foresight and the control and organization of behavior."

Ruth L. Munroe has described the psychopath as one whose behavior seems primarily characterized by a complete absence of moral scruples. Often winsome and charming when it suits his purpose (or perhaps most of the time), the psychopath may not hesitate to sell out his best friends for the sake of personal advantage, and may not even balk at murder if seriously frustrated. His only rule of conduct seems to be one of expediency.

A psychopath, Munroe remarks, may commit a "crime of passion" on the spur of the moment and begin cold-bloodedly to cover his tracks a moment later. The cheerful indifference or "appropriate" grief he may show five minutes later is not superbly skillful acting. He actually feels calm, or may even feel genuinely sorry for his victim, although deep, personal remorse is foreign to him. He may steal impulsively and be caught through carelessness—not because he unconsciously craves punishment, as do some neurotics, but because he quite genuinely forgets about the possible consequences when his mood shifts.

What are the causes of the psychopathic personality?

The search for causes is still inconclusive because no research has shown decisively whether the biological or the developmental influence alone is critical or crucial.

Henderson states that such analysis of psychopathic states as has been attempted is on a descriptive basis and gives little or no hint as to

how the psychopathic condition is caused. There have been references to constitutional and environmental factors, but there has been little attempt at correlation and an entire absence of specific etiological factors.

The biological hypothesis maintains that brain damage, as detected by electroencephalogram, or other disturbances, whether inherited or acquired by injury, is the cause of psychopathy.

It has been postulated that a child constitutionally weak in conscience could be exposed to the finest home influence or the best religious training and still be unable to acquire acceptable standards of behavior. Conversely, a child who has a normal conscience but who is not trained in established standards of morality might or might not achieve the accepted paths of behavior.

On the question of environment, predisposition was once assumed to be the sole causative factor, but today there is little doubt that the psychopathic condition in some instances is brought about predominantly by life experiences. Some psychopaths are victims of faulty development, and have been shown to have been deprived of intimate relationships with parent figures from infancy or early childhood.

Lauretta Bender's interest in the problem was aroused when many psychopathic children turned up at Bellevue Hospital, New York City, after infancy in an institution that provided good physical care but little opportunity for affectional ties with adults, or with other children. Anthropologists have reported a similar condition among primitive people when cultural conditions withhold sustained care of children and a continuity of affectionate attention.

The following evidences have been cited to support the hypothesis of an organic etiology: early development of symptoms; the homogeneous nature of the psychopathic personality as a type; consistent and hopeless repetition of the same behavior; constant deficiency of other factors besides conscience, as emotional dulling and sexual deviations; posttraumatic behavior problems simulating psychopathic personality; and pathological brain wave findings. (See *Organic Brain Disorders*)

L. Bovet maintains that there is no valid reason for refusing to admit at least the possibility that constitutional and hereditary factors can so influence character formation as to predispose some persons to delinquent behavior. Since it is agreed that hereditary and constitutional factors can determine to some extent height, body-build, and intelligence level, he argues, why may they not have an important influence upon character? (See *Constitutional Variation and Mental Health*)

Edmund Conklin considers constitutional psychopathology an intrinsic defect. He finds support for this viewpoint in the fact that the troublesome traits in the psychopath can usually be traced back to comparable behavior problems in childhood. Psychopaths in childhood, he recalls, show a history of marked stubbornness, anger spells or temper tantrums, sulkiness, destructiveness, quarrelsomeness, shamelessness, and such indications of nervous weakness or delayed development as enuresis.

E. A. Strecker and Franklin Ebaugh assert that in a strict sense psychopathic personality is a constitutional reaction, a kind of feeble-mindedness other than intellectual in which there is commonly defective emotional control and a lack of inhibition in the volitional sphere. The record of the inferior, they find, is clearly written in his inadequate response to ordinary life situations. Many criminals, moral delinquents, tramps, and drug addicts are said to belong in this category. The pathological personality may be the background for episodic psychotic attacks of irritability, excitement, depression, paranoid outbreaks, transient confused states, and prison psychoses.

Are psychopaths generally held legally responsible for their misdeeds?

In recent years legislative, judicial, and public opinion have swung sharply toward the viewpoint espoused by social therapists that the offender himself, and not the crime with which he is charged, should be the basis for dispensing justice. As the traditional rigid adherence to the letter of the law has given way to an increasing tendency to permit circumstances to alter cases, the offending psychopath, as well as other offenders with pathological histories, has had a better chance than formerly to be adjudged legally irresponsible, or at least to win the court's assent to the principle of treatment rather than punishment.

Until the last decade or two, justice in cases involving psychopathology was largely meted out under the criterion of the M'Naghten Rule, established in England in 1843, which posed the question whether the accused was capable of knowing right from wrong and was aware of the nature and quality of his act. Today about twenty states have progressed to the "irresistible impulse" test, under which it is possible for judges and juries to decide whether criminal responsibility is mitigated by a recognizable pathology. Even where a verdict of not guilty by reason of insanity is denied, sentencing and parole procedures often take account of the offender's need for psychiatric treatment rather than punitive incarceration. (See *Durham Decision*)

In cases of major crimes, the pressure of juridical and public opinion makes it more difficult to establish that the offender is not legally responsible. But since the unpsychotic psychopath commonly commits crimes of only a moderately serious nature, more often involving money or property than life and limb, his legal counsel frequently is able to establish that he is not legally responsible, or at least to obtain a less severe penalty in the light of his condition.

However, psychopathy is often a borderline condition, with indistinct or sporadic symptoms, and with professional opinion differing as to whether it is classifiable as insanity. Psychiatric testimony faces subtle difficulties in persuading judges and juries that the psychopath is entitled to the benefit of a judgment of irresponsibility. Nevertheless, perhaps largely because of the easily changeable, opportunistic, and resourceful character of the psychopath himself, who is typically proficient at cajoling the unwary, it does appear that more often than not he is able to escape the full weight of prosecution.

On the other hand, McCord and McCord comment that many judges hesitate to abandon the prevailing standards of responsibility for fear of destroying punishment's effectiveness as a deterrent to criminal behavior. They quote from Roscoe Pound the theoretical premises of the penal law: "Historically, our criminal law is based upon a theory of punishing the wicked will. It postulates a free agent confronted with a choice between doing right and wrong and choosing freely to do wrong. It assumes that the social interests are to be maintained by imposing upon him a penalty corresponding exactly to the gravity of the offense."

McCord and McCord reason that the criminal law ignores the complexity of causes that prompt man's behavior. They consider that probably no criminal, whether mentally disordered or not, deliberately decides to commit an evil act. His behavior cannot reasonably be depicted as the conscious choice of an independent free will; rather, the actions of all criminals come from a complicated interplay of biological, social, and psychological causes. Thus, it is found unrealistic to try arbitrarily to distinguish the "sane" from the "insane" criminal on the basis of these criteria.

"In theory," they contend further, "the tests of insanity are unrealistic; in practice, they are unwieldy. The psychopath, together with other criminals, is punished by imprisonment, although imprisonment rarely changes him. Later he is released and he repeats his pattern of behavior."

Some of the objections to the traditional concepts of punishment have been met by the State of California. There, after the courts sentence a felon to prison, the state's Adult Authority assumes responsibility for his treatment and release. Every sentenced offender passes through a reception center, which administers a thorough social-psychological examination. Under a general treatment plan prescribed for the individual, he is assigned to an institution that best meets the needs of his maladjustment. His release date is governed roughly by statute.

Some aspects of California's system have been adopted by Maryland, whose courts endeavor to sentence the offender rather than the crime. An even more advanced system has been proposed by Sheldon Glueck as a means of bypassing the problem of irresponsibility. He suggests separation of the two functions of criminal law, determination of guilt and imposition of sentence. The judge and the jury would ascertain only the guilt or innocence of the accused. If found guilty, the offender would be remanded to a treatment tribunal. This would be a board consisting of, or including, behavioral scientists, who would gauge the sentence not on an arbitrary definition of responsibility but on the scientific evaluation of the nature and causes of the offender's behavior.

As an expression of the mental health professionals' viewpoint, D. K. Henderson has asserted in his *Psychopathic States*: "Most psychiatrists, many prison officials, and some judges are beginning to appreciate that those who are afflicted are distinctive types, emotionally and instinctively unstable, who have no more power to control their conduct than the epileptic patient, his fit, or the malarial patient, his ague. They cannot be arbitrarily designated mad or bad in the strict sense of either word, but are so constituted and uncontrolled as to create a problem which has so far defied interpretation as to cause, course, or outcome."

The psychiatrist presents this vein of opinion, not to shield or condone the psychopath, but merely to record the facts as they are, so that society can determine, in an informed way, what may best be done to protect itself from the encroachments of pathological offenders and to protect such sufferers as the psychopaths from themselves. (See *Law and Psychiatry*)

Why are so many psychopaths able to evade penalty and restriction?

To begin with, there are many psychopaths whose antisocial tendencies are so modified or so masked that they never come into overt conflict with the law, and they even evade professional observa-

tion. The personality pattern may be such, or the person's position in life may be so privileged or protected, that the psychopathic manifestations are eclipsed by other facets of behavior or are simply concealed from authoritative scrutiny. We know that only a small percentage of all mentally ill persons, including those with disorders entailing a potential social danger, ever reaches the stage of hospital treatment or juridical arraignment.

Second, as we have seen, the psychopath usually is a past master not only at getting himself into trouble, but also at squirming his way out of it. When his aggressive or parasitic behavior reaches the point of outrage, when his mask of affability falls, and when his victims or other observers at last seek retributive action, even then the psychopath often is able to persuade them that it is all a misunderstanding or that there are no valid reasons why he should be brought to book. He is a shrewd actor and an adroit speaker and has instinctively sharpened his ability to use words to sway an audience. Even when the psychopath's behavior has become so brazen and his coups are so outrageous as to bar the possibility of the forgive-and-forget sequel, the victim may still hesitate to seek legal or other redress in view of the unfortunate and uncontrollable nature of the offender's pathology.

Paradoxically, the psychopath has the faculty of producing in other people emotional reactions that he is incapable of feeling himself. He is a practiced student of human nature, though not introspectively so. His powers of persuasion, alluring gestures, disarming manner, and glib tongue frequently win for him a favorable decision from a judge or other figure of authority. When all these artifices have failed, the psychopath may resort to affected injured feelings or to a dramatic appeal for sympathy that is convincing enough to mollify even the most callous antagonist.

Though the psychopaths' score in winning impunity or mercy against ominous odds is remarkably high, naturally many of them fail to escape the consequences of their transgressions and go on to prison or to hospital commitment. But so indestructible is their egocentric aplomb and so resilient their capacity for wheedling an advantage that the transition to imprisonment or restraint merely brings on a new stage in their inveterate struggle to come out on top. In prison or hospital the psychopath strives at once to dominate and victimize not only his associates but also those who wield authority over him. It is not unusual for him to extract favorable treatment from his mentors

and to play the role of a worthy supplicant so convincingly that he is soon in line for probation or parole.

How early can the symptoms of the psychopathic personality be recognized?

Many psychiatrists have reported observation of symptoms of psychopathic personality in children at an early age. For example, Lauretta Bender's interest in the disorder was aroused when she noticed symptoms in children in a large city hospital. Subscribers to the hypothesis of constitutional origin tend to the theory that the psychopathic component is present from birth but that alarming symptoms seldom appear until the self-supervising stage of adolescence is reached.

This writer has suggested periodic mental examination of all school-children which would pay as much attention to emotional factors as is normally given to the standard physical criteria. If routine psychiatric evaluation of pupils were practiced, there is little doubt that indications of psychopathic liability, as well as other emotional disorders, would be detected in many cases. Under present conditions, at least a suspicion of such rudimentary difficulties is often found in institutional settings, in clinics, and in private practice, but it is obvious that these chance diagnoses represent only a tiny proportion of existing cases. Furthermore, the likelihood of any follow-up procedure with a view to treatment is deplorably small in these circumstances.

The experienced examiner can detect the psychopathic personality from certain mannerisms and gestures as well as from the characteristic language of the disorder. Among other surface indications, the psychopath is marked by volubility and a facile tongue, and he may bite his fingernails or frown in an attempt to simulate worry or a troubled mind. These and other gestures are a bogus byplay that, together with a total impression of the person, indicate to the practitioner something of the nature of the disorder. The psychopath's reactions are not so much those of one with nervous symptoms or mental worries as they are his own conception of how a person who is under mental stress should act.

A longitudinal study of the occupational record of a suspected psychopath is a helpful tool in diagnosis. Irresponsibility, lack of sustained effort, and impulsiveness are usually reflected in the work history. Information about the patient's relations with his fellow

workers, associates, and family are also useful in reaching an estimate of the personality constellation. The psychopath's attitude is quickly betrayed by his pseudonaïve expressions, his facility in blaming others for difficulties in which he is involved, and his admission of the most shameful behavior without any apparent feeling of self-reproach or of real insight as to the basis of his disorder.

Although psychopathic symptoms may be described as conspicuous and well-defined, in reality they vary from case to case. The layman should beware of attempting parlor diagnosis in a field rightfully reserved for professional, experienced acumen.

What effect does a psychopathic child or adult have on his family?

Since the kind of relationships that a given child may have with his parents or with other members of the family are so varied, a representation of a static family constellation or of given parental characteristics is not enough to explain the deep effects of the environment on the emerging psychopath. The important influences consist of the ways in which the child and parents relate to each other and the way in which the child internalizes the meanings of these relationships.

Although certain *forms* of parent-child relationships may contribute to psychopathic behavior, the *context* of the interaction cannot be overlooked. Some parents may be so undisciplined emotionally or so perverse in life pattern that the child, having no other role models, may identify with them and then internalize perverse forms of behavior. Having received the parents' sanction from their behavior, he accepts their criteria of right and wrong and may imitate their behavior with little or no guilt feelings.

In the process of socialization, the child, by identifying with those in his environment, internalizes their viewpoint about himself and thus may become disturbed and even disordered if the parents are emotionally undisciplined. Such a deprived child's relationships with adults are usually very meager, barren, and distant. His emotions, reflecting these thin relationships, are shallow, simple, and direct, for he does not have the opportunity to cultivate intense or complex feelings toward other persons.

The adult psychopath is the world's most consistent nonconformist, and his recurring cycles of emotional turmoil and pent-up tension lead to behavior that is demoralizing to those around him. The family usually suffers most from this constant state of emotional upheaval.

Therefore, the sooner the psychopath is taken out of the home, the sooner the turmoil will end, and the disintegration of the family circle may be prevented or arrested.

Many psychopaths show a predominance in manifestations of jealousy and suspicion, and paranoid episodes frequently develop in the ever-changing cycle brought about by the constant friction and irritations of social intercourse. This, in turn, leads to the narrowing of all forms of social contact. Thus, the family not only is subjected to the mischief, expense, and annoyance associated with the psychopath's behavior, but finds its social contacts spoiled and compromised, if not cut off entirely.

The community's attitude toward such a situation is likely to be colored by the misunderstanding, lack of sympathy, and dread-filled resentment so often manifested toward the strangeness of psychopathological behavior. Even where neighbors attempt to be sympathetic, other elements in the community are likely to shun and victimize the family because of its disordered member. The psychopath himself, with his proclivity for alternating unction and offense, is capable of sowing chaos in the neighborhood as well as within the home. Thus, the family may find itself in a doubly unbearable situation if it injudiciously attempts to tolerate its disordered member at home.

When should the psychopath be hospitalized?

The psychopath who exhibits criminal or other offensive tendencies should be placed as early as possible in a mental hospital for an extended period of time. This should be done as a sensibly prudent means of protecting him, his family, and society. Above all, it is the only feasible measure of guarding against the possibility of his committing a serious crime. Even when the disorder appears to be incipient or latent, hospitalization should be seriously considered as a means of obtaining the advantage of early treatment.

Diagnosis and treatment of the psychopath, together with the resolution of any questions concerning him, should be entrusted only to a qualified psychiatrist, who is specifically trained in recognizing and dealing with such psychopathology. Although other advisers may be consulted in confronting the sometimes complex problems involved in a case of mental illness, it is essential that the psychiatrist determine the psychomedical aspects of the situation.

The psychopath should be placed in an institution with a minimum

of firm authority and regulation and should be protected, to a maximum extent, from difficulties arising out of poor judgment and moral indiscretions. In such a setting the psychopath is at his best. He improves physically, and with regularity of living habits and decrease in responsibility he may attain relative emotional stability, with marked diminution of his pathological symptoms.

To a large extent, the psychopath's criminal behavior is confined to the general realm of fraud or cheating. Although such offenses can cause the family and the community considerable embarrassment and indignation, they are less menacing than the crimes of aggression that typify some disorders. Nevertheless, the tendency to such pathology entails the obligation to shield the patient from the risk of culpable behavior. Furthermore, the psychopath's moods are so unstable and his liability to resentments so constant that the possibility cannot be ruled out that he might commit a crime of violence. Therefore, the counsel of early and prolonged hospitalization connotes both insurance of the family's protection and precaution against the stigma of criminal involvement.

What kinds of treatment are available for the psychopath?

Most of those psychopaths who run afoul of the law find themselves in penal institutions, where psychiatric treatment is limited or nonexistent. Others arrive in mental institutions, few of which have any provision for treating psychopaths. Most of the hospitals that have attempted such therapy lean to a judicious mixture of fairness and consideration with firmness and unremitting discipline.

Aside from active, planned psychotherapeutic intervention—and concurrent with it—treatment of the psychopath is mainly environmental. Recognizing the psychopath's basic problems, the practitioner tries to get him into an environment in which the demands made upon him are consistent with his difficulties.

Ruth L. Munroe reports that psychopathy presents a difficult problem in psychoanalysis because the patient cannot easily establish a solid transference to the therapist. Some experiments have tried to capitalize on the theory that the superego is never totally absent but is sometimes immature and burdened by conflicts. The procedures are not psychoanalytic but are conducted or supervised by psychoanalysts, who base their approach on their special understanding of the patient's problems. (See *Psychoanalysis*)

Is treatment successful?

The gist of psychiatric testimony appears to be that therapy has been successful in some cases in effecting what amounts to a remission or control of the symptoms, but not in achieving a definite cure.

Many investigators contend that the psychopath is not amenable to change, since his difficulty can be observed in early childhood and he learns little from experience. Though the psychopath may resolve to change, to conform, or to restrain himself for a limited period, he apparently cannot attain a long-term disciplined redirection.

Raymond G. McCarthy finds that in the true psychopathic personality the inherited traits and inborn characteristics are so dominating and persistent that medical care, training, environment, and other therapeutic measures meet with the same fixity of resistance and ineffectiveness.

On the other hand, A. H. Maslow maintains that success is possible. He asserts that therapy in children and adolescents can be effective if the individual's life situation is still easily changeable. He says that psychoanalytic therapy and/or management of the group and of the home situation may lead to success.

Therapy, it is contended, can be effective for the adult if he has successfully completed a period of occupational training, if he has a need for attachment and self-criticism, and if he has a sense of guilt strong enough to make a therapeutic relationship possible.

Though treatment is admittedly difficult, its success is held by some to be dependent upon the depth of emotional attachment achievable between therapist and patient, the amount of insight present, and the psychopath's capacity to elucidate his problems rather than to act them out impulsively.

Overholser has commented: "One can understand why some psychiatrists are pessimistic regarding results in treating sociopaths, but an attitude of total incurability seems to be not only unwarranted in fact but wholly unpsychiatric."

PSYCHOPHARMACOLOGY

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What is psychopharmacology?

Psychopharmacology covers two clearly related but separable areas. First, it covers the study of the effects of drugs on psychological functioning and the mechanisms through which drugs affect such functioning. Psychopharmacology is, therefore, concerned with the effects of drugs on emotional states, on psychomotor performance, and on many other aspects of psychological functioning in psychiatric patients, in normal subjects, and in animals. It is also concerned with the effects of drugs on the functioning of the central nervous system as indicated by changes in its electrical activity or in its biochemical functioning.

Psychopharmacology also covers the therapeutic use of drugs in the treatment of psychiatric or emotional disorders. Although the basic science aspects of psychopharmacology described above are of long-range importance in the field of mental health, this article will focus primarily on the clinical aspects of psychopharmacology.

What kinds of drugs have psychopharmacological effects?

There are five major classes of drugs currently used in the treatment of psychiatric and related disorders. These drugs can be classified as (1) major tranquilizers; (2) minor tranquilizers or sedatives; (3) antidepressants; (4) stimulants; and (5) psychotomimetics.

What are major tranquilizers?

Major tranquilizers are drugs with demonstrated effectiveness in the control of the relatively severe psychiatric symptoms, commonly associated with schizophrenia and other psychotic states. The specific symptoms include severe agitation, delusions, hallucinations, disor-

ganization of thought processes, excitement, and panic, as well as abnormal apathy and withdrawal. These symptoms are most often found in patients hospitalized for psychiatric disorders, and the major tranquilizers' most effective use has been in the treatment of these patients. These drugs also are relatively effective in the treatment of lesser degrees of anxiety and tension, commonly found in patients with neurotic symptoms who are usually treated as outpatients.

The major tranquilizers include a number of compounds, called phenothiazine derivatives, that are chemically similar to chlorpromazine. Chlorpromazine was the first drug of this group to be identified, and was first used in the treatment of psychiatric patients by J. Delay and P. Denniker in France, in 1952. Although the other phenothiazine derivatives differ somewhat from chlorpromazine in the dosage required to produce clinical improvement and in the type and nature of their side effects, there is at present no strong evidence that most of these drugs are substantially different from each other in their overall clinical effects. However, a patient who has not responded to one drug in this group may often show a satisfactory response to a second phenothiazine derivative.

Reserpine and other related Rauwolfia alkaloids are also available for prescription use and appear to have similar properties. These alkaloids, as a group, are somewhat slower acting and may be a little less effective in the treatment of severe psychiatric symptoms than are the phenothiazines, although some patients who have failed to respond adequately to a phenothiazine drug may nevertheless respond to a Rauwolfia alkaloid.

What are minor tranquilizers?

The minor tranquilizer group encompasses a wide variety of drugs of diverse chemical structure used to relieve anxiety and tension, but they have no real effect upon the more severe psychotic symptoms. They differ from sedatives such as the barbiturates in that they have a beneficial effect on anxiety without producing significant amounts of sedation or drowsiness. However, most of these compounds produce drowsiness when used in higher dosages, and some patients may experience drowsiness as a side effect even at usual clinical dosages.

The first compound in this group to be widely used and to attract popular attention was meprobamate, which is marketed under the trade names of Miltown and Equanil. Subsequently, many other compounds with similar properties have been identified.

The evaluation of the exact degree of effectiveness of these minor tranquilizers is made difficult by the transitory nature of anxiety symptoms in some patients and by the relief from anxiety often experienced by patients following consultation with their physician, irrespective of the type of medication received.

What are antidepressants?

Antidepressants are drugs with a clearly demonstrated therapeutic effect upon abnormal mood depression, sadness, or melancholia. One such drug, imipramine, has a chemical structure similar to that of the phenothiazines but possesses a clear effect upon severe depressive symptoms and lacks the major tranquilizing properties of the true phenothiazines. In order to be effective, it must be taken steadily for several weeks. Real clinical improvement usually does not occur before seven to ten days of drug administration and may not emerge clearly for two or three weeks.

Several other antidepressant drugs share in common the ability to inhibit an enzyme, monoamine oxidase, which metabolizes certain biologically active, naturally occurring chemical substances in the central nervous system, including adrenaline, noradrenaline, and serotonin. The effects of these drugs may well be related to the alterations they induce in the biochemistry of the brain, although this has not been definitely proved. In any event, these drugs also are slow to take effect. Clinical improvement may not occur until the drug has been taken for two to three weeks.

What are stimulants?

A number of drugs, including amphetamine and dextro amphetamine, commonly known under their trade names, Benzedrine and Dexedrine, have an immediate stimulating effect upon the central nervous system and upon behavior, often causing overtalkativeness, increased activity, and an inner sensation of speeding of thought processes, sometimes associated with a feeling of euphoria or increased well-being. These drugs can relieve some of the adverse behavioral effects of fatigue. They are, however, often not effective in the treatment of mood depression. Depressed patients frequently perceive their effects as unpleasant or undesirable.

What are psychotomimetics?

The psychotomimetic drugs, which include lysergic acid diethylamide (L.S.D.), a synthetic chemical, and mescaline derived from pe-

yote, a cactus, all share the property of being able to produce bizarre psychological effects in normal subjects. These effects include unusual visual sensations, distortions of the perception of sounds, feelings of unreality and of bodily change, and in some individuals, true hallucinations and delusions. These substances have been used in some cultures to produce ecstatic, semireligious states. Although there has been some preliminary investigation of their use in psychiatric treatment, particularly as adjuncts to psychotherapy, this use is open to serious question since the long-term effects of these drugs are not clearly understood, and patients may show serious suicidal tendencies or other highly undesirable bizarre behavior while receiving the drugs.

Although the psychological effects produced by these drugs are often bizarre in nature, there is general agreement that the drug-induced condition is *not* very similar to the psychological phenomena observed in schizophrenia.

Will the new drugs empty our mental hospitals?

Probably not. From 1955 to the end of 1961 there was a gradual decrease of about 5 per cent in the total number of resident patients in our public mental hospitals. This occurred despite an increase in the number of new patients being admitted to these hospitals. It should be noted that prior to 1955, there had been a steady gradual increase in the number of resident patients every year for more than eighty years. Nevertheless, a report from New York State indicates that there has been only a 20 per cent annual decrease in the number of schizophrenic patients beginning their fourth year of continuous hospitalization since the advent of drug treatments. Thus, although the number of chronic patients who constitute the hard core of treatment-resistant patients likely to spend much of their lives in mental hospitals is being significantly decreased, there is no evidence that this chronic group is being completely eliminated by present treatment methods. A continuing gradual decrease in the number of resident patients in our public mental hospitals can be expected, but no rapid emptying of the hospitals appears to be occurring.

Is this decrease in the number of hospitalized mental patients due to the new drugs?

Inasmuch as there has been a gradual improvement in all aspects of treatment in public mental hospitals during the past fifteen years, it is hard to be certain that the drop in number of patients, which occurred at the time the new drugs were first widely used, was in fact

due to the drugs, but many experts believe the drugs have played a significant role. Certainly drugs have greatly reduced the amount of disturbed and violent behavior in mental hospitals, and have enabled staffs to spend less energy controlling disturbed behavior and more time on more positive therapeutic activities. The drugs may have assisted in the widespread application of the "open door" policy to many public mental hospitals and have certainly proved useful in the treatment of patients receiving psychiatric services in general hospitals. They have also accelerated the development of aftercare clinics for the treatment of patients released from mental hospitals. There is excellent evidence that drugs can be effective in preventing rehospitalization and make possible the use of alternatives to hospitalization, such as day care centers where the patient can receive effective treatment during the day and can return home each evening.

Can the drugs currently used for the treatment of mental illness cure mental illness?

No, they cannot. However, few drug treatments in use in any area of medicine possess this property. Psychoactive drugs do compare favorably with drug treatments in current use in cardiovascular conditions or gastrointestinal conditions. In many cases, the major tranquilizers can substantially reduce the patient's discomfort and the intensity of his symptoms. Acutely ill, hospitalized patients can be returned to the community more rapidly, and chronically ill patients are enabled to adjust better in the hospital and are often helped to achieve a stable adjustment outside the hospital through the use of maintenance drug therapy.

How long must an emotionally ill person continue to take drugs?

There is strong evidence that patients with chronic schizophrenic illnesses with recurrent hospitalizations or a single prolonged hospitalization should continue to take tranquilizing drugs for a prolonged period, inasmuch as discontinuance of the medication prescribed by a physician markedly increases the likelihood of the patient having a recurrence of symptoms. It is not known whether continued drug treatment is necessary or desirable following single acute schizophrenic illnesses or following depressive illnesses. Cautious reduction in dose and cessation of drug treatment is often successfully attempted by the physician after patients have stabilized themselves in the community. In the treatment of neurotic conditions the prolonged use of tranquil-

izing drugs must be questioned, since there is some danger of emotional dependence on the medication.

Do these drugs have harmful effects if taken for a period of months or years?

The very rare but potentially serious side effects of the major tranquilizers include jaundice, harmful decrease in the number of white blood cells, and drug-induced neurological symptoms such as stiffness or tremor. These usually occur early in the course of drug treatment. There is no real evidence that prolonged treatment is harmful.

Can these drugs be used to treat children who have emotional disorders?

There is no evidence that these drugs have harmful effects upon children with emotional disorders. Sometimes they provide symptomatic relief. In general, however, the tranquilizing drugs appear to be less effective in children with emotional disorders than they are in adult psychiatric patients.

Are these psychopharmacologic agents used for the treatment of non-psychiatric conditions?

Yes, they are. Reserpine and the other Rauwolfia alkaloids are commonly used for the treatment of high blood pressure, and many of the phenothiazines are used to treat nausea and vomiting. The monoamine oxidase inhibitors are also used in the treatment of hypertension and of angina pectoris. Several of the minor tranquilizers have muscle-relaxing properties and are used for the treatment of muscle spasm, back strain, and related conditions. Patients with nonpsychiatric medical conditions sometimes become unnecessarily upset on finding that they have been given a tranquilizer.

Who can prescribe psychopharmacologic agents?

These drugs are used relatively frequently by physicians in all specialties, including general practitioners. In special circumstances they may also be utilized by dentists to relieve tension and anxiety associated with dental conditions. They may not be prescribed by non-medical professionals in the mental health disciplines, such as psychiatric social workers and psychologists, although patients receiving therapy from psychologists or psychiatric social workers in medical

settings such as mental hygiene clinics, aftercare clinics, or psychiatric clinics of general hospitals may concurrently receive drug treatments from physicians in the same treatment facility.

Do drugs interfere with psychotherapy?

There is little clear evidence concerning the effects of drugs on psychotherapy. Many psychiatrists combine the use of drugs with the use of both intensive and supportive types of psychotherapy. Many patients who are relatively inaccessible to psychotherapy because of the severity of their illness can be benefited by drugs to such an extent that they can then effectively enter into active psychotherapy. Although it is theoretically possible that drugs might relieve symptoms so well that the patient no longer would be interested in working out his emotional problems in psychotherapy, appropriate use of these agents should enable drug treatment and psychotherapy to be effectively utilized together.

Will drugs replace psychotherapy?

Drugs have been most effective, to date, in hospital settings where opportunities for intensive psychotherapy are very limited; they are probably less effective in treatment of neurotic conditions, where psychotherapy is more commonly employed. It appears unlikely that drugs will be able to offer the same benefits as skilled psychotherapy. However, a combination of drug treatment and supportive psychotherapy may enable substantial help to be provided to patients with emotional disorders who, for a variety of reasons, might not be suitable for intensive psychotherapy or might not have access to such intensive psychotherapy. On the other hand, there is strong suggestive evidence that the attitudes and skills of the therapists may significantly affect the response of patients to drug treatments.

Do drugs interfere with driving?

Probably not, under ordinary circumstances. During the early use of a psychoactive drug, particularly a tranquilizer, some sleepiness or unsteadiness may be experienced as an undesirable side effect. Patients should check with their physicians about the advisability of driving whenever a drug of this type is being used. Patients should, of course, not drive when sleepy or unsteady. Since severe anxiety or any symptoms of emotional illness may interfere with a patient's ability to drive carefully, it is entirely possible that in some cases drug treatment

may actually improve the patient's driving. Decisions concerning the advisability of patients driving under the influence of any given psychopharmacologic agent must be made by the physician in each individual case, taking into account the nature of the patient's illness, the drug being used, and the effects of the particular drug on the individual patient.

Do drugs affect the patient's response to alcohol or other nonpsychoactive drugs?

The phenothiazines, the minor tranquilizers, and monoamine oxidase inhibitors all probably accentuate the sedative effects of a given amount of alcohol. The extent of seriousness of this combined effect will vary considerably with the type of drug used, the dosage with which it is being used, the amount of alcohol taken, and the susceptibility of the individual patient. Although alcohol, if used, should probably be taken cautiously by patients under psychoactive drug treatment, this is a decision that must be left to the judgment of the individual physician. The phenothiazines and the monoamine oxidase inhibitors also tend to increase the extent and duration of the sedation produced by barbiturates and other sedatives. The monoamine oxidase inhibitors also have a tendency to interact undesirably with local anesthetics and with stimulants. In general, patients receiving psychoactive drugs should take other medication only with the approval of the physician administering the psychoactive drug.

Is it all right to borrow tranquilizing drugs from friends?

No, it is not. These drugs should be taken only on the explicit advice of a physician.

Can one become addicted to any of these drugs?

One cannot become addicted to these drugs in the sense of "addiction" as it is used to describe morphine or heroin or other opium derivatives. However, large doses of meprobamate and some of the other minor tranquilizers, if given for prolonged periods, can produce a state of physiological dependence. If a patient abruptly stops taking drugs of this type, he may experience agitation, anxiety, and occasionally, convulsions. In ordinary clinical practice, such effects are rarely encountered since large doses of these drugs are not usually used for long periods and since treatment is rarely stopped abruptly. When the

dosage is reduced gradually, undesirable withdrawal symptoms of the sort described here are not encountered.

Do these drugs affect all people in the same way?

No. There is considerable variation in the effects these drugs will have. For example, a high dose of a phenothiazine derivative, which may be extremely helpful in the treatment of a severe schizophrenic excitement, will produce extreme drowsiness, weakness, and fatigue in a normal or a neurotic individual. Occasionally, a tranquilizing or sedative drug will make some individuals excited or jittery, and a stimulant such as amphetamine will produce apparent tranquilization. For reasons that are poorly understood at present, these drugs can produce unusual and atypical reactions in some patients. Also, as previously noted, these drugs are by no means uniformly effective even in patients whose psychiatric condition would most likely benefit from a particular drug.

Are drugs useful in the treatment of alcoholism?

Several drugs are quite useful in the treatment of delirium tremens and states of acute excitement in alcoholics. One special drug, disulfiram (Antabuse), can be used for alcoholics to prevent them from drinking, since this drug interacts with alcohol in the body to produce nausea, vomiting, and a variety of other unpleasant somatic symptoms. By and large, however, the various types of psychopharmacological agents used in other types of psychiatric conditions are of little help in the treatment of alcoholism, although individual drugs may be helpful in individual cases.

Can psychoactive drugs cure mental retardation?

No. The tranquilizing drugs can be helpful in the symptomatic treatment of disturbed behavior or abnormal anxiety encountered in some mentally retarded patients, but these drugs appear to have no real effect on intelligence or on social adjustment, except as they may provide relief from other psychiatric symptoms that interfere with optimal functioning of mentally retarded individuals.

Are these drugs helpful in psychiatric conditions of later life?

Drugs may provide symptomatic relief for anxiety, agitation, or depression encountered in elderly patients with a psychiatric illness.

There is no evidence that they have any beneficial effect on organic brain changes produced by hardening of the arteries or by the aging of the brain. Memory defects or mental deterioration encountered in the aged are not affected, except as such symptoms may be exaggerated by anxiety or depression.

Does science understand how these drugs act?

Although a good deal is known about the effects of many of these drugs on the electrical activity of the brain and on the biochemistry of the brain, and although there is considerable information about the effects on the psychological functioning of animals and normal human subjects as well as on psychiatric patients, it cannot be said that the mechanisms of actions of these drugs are fully understood. Since these drugs produce complex changes in brain function, since the brain itself is a complex organ, and since the relationships between changes in brain function and changes in behavior are also only partially understood, it is likely that a full and complete understanding of these drugs will not be achieved in the immediate future. Nevertheless, it is worth emphasizing that the mechanisms of action of many other effective drugs used in other medical conditions, as for example, aspirin, also are not too well understood. Nevertheless, more than enough is known about these drugs to permit their safe and effective clinical use.

Will drugs be developed that can really cure mental illness?

This is very difficult to predict. Much continuing research both within drug company laboratories and within university and hospital research facilities is devoted to the identification and study of promising new drugs. It is very likely that new drugs will be discovered and that some of these will be more effective or more specific than our present agents. Since much research is being devoted to the study of the biological and biochemical basis of mental illness, it is also possible that some major discovery in this area may lead to the development of a rational and specific treatment for one or more types of mental illness. It is also possible that further study of our present drugs, or investigations dealing with drugs developed in the future, may lead to the discovery of biochemical or neurophysiological abnormalities underlying mental illness.

PSYCHOSES

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What are psychoses?

Psychoses are severe mental (emotional) disorders marked by symptoms that a layman most readily attributes to a deranged mind: grossly disturbed, bizarre and unconventional behavior, irrationality, conspicuous mental or emotional abnormality. Most patients who require repeated or prolonged hospitalization in mental institutions are suffering from psychoses.

However, since there is no consensus as to what constitutes normality and mental health, mental abnormality remains a problematical concept. What may appear as grossly abnormal behavior in one culture or historical epoch, may seem less so in other situations. (See *Neurosis and Normality*) Consequently, as is the case with the neuroses, the psychoses are subject to continuing controversy as to scope and limit. (See *Neuroses*) This controversy is reflected in the various definitions and theories presently prominent, which partly conflict with each other.

What are the various definitions?

Strictly speaking, the term psychosis denotes a state of mind, a psychical process, or mental act. As a medical term it must be differentiated from the legal term, insanity. Although many psychotic patients are considered insane from a legal point of view, others are not. (See *Law and Psychiatry*)

In the field of mental illness the psychoses may first be defined by what they are not: they are not neuroses, they are not mental deficiencies, and they are not character disorders (including sociopathic reactions). However, in many cases there is overlapping of symptomatology. Therefore, the demarcation of the psychoses from these other groups is frequently difficult or problematical. (See *Mental Retardation; Character Structure; Psychopath or Sociopath*)

Second, the psychoses can be defined by what they are. The following definition is currently offered by the American Psychiatric Association's

Committee on Nomenclature and Statistics: "A psychotic reaction may be defined as one in which the personality, in its struggle for adjustment to internal and external stresses, utilizes severe affective disturbance, profound autism [self-absorption] and withdrawal from reality, and/or formations of delusions [false beliefs] or hallucinations [perceptions not actually perceptible]." This definition, in order to become meaningful, requires some understanding of the theories underlying it. However, before an account of these theories can be given, the following question must be answered.

What are the roles and relationship of mind and body in the psychoses?

Certain answers to this question, problematical as they may be, have greatly influenced the theorizing about the psychoses.

In general, all mental processes such as talking, writing, learning a language, etc., are related to processes occurring in the body and particularly in the brain. First, how relevant is the understanding of what happens in one sphere to the understanding of what happens in another? Second, how can this relationship be understood and conceptualized? The two questions are interrelated. It is only after the relevance of the one sphere to the other is evident that the significance and relationship of the two spheres to each other becomes a problem.

For example, in learning a language we normally need not know what brain processes underlie and accompany this learning. However, a brain tumor or an infectious disease might interfere with the learning capacity. In this case, what happens in the brain to some degree becomes relevant to the learning of the language.

Similarly, existing theories about the psychoses are colored by what each observer considers their most relevant aspects. Roughly, based on such judgment of relevance, one can currently differentiate three basic modes of theorizing about the psychoses: (1) there are theoretical approaches attributing greatest relevance to the bodily processes that presumably determine the psychoses; (2) there are approaches emphasizing the importance of the life experience of the psychotic person and of the dynamic significance of his symptoms, and which consider the physical aspects irrelevant; and (3) there are theories which, in one way or another, try to integrate these two positions. These theories are commonly labeled "pluralistic, integrative," etc.

To a degree, both the organic and the dynamic approach to the psychoses seem to be supported by the facts of medical experience.

There are many psychoses in which the underlying bodily processes appear most relevant to their understanding. In these cases the psychotic symptomatology is triggered by some clearly discernible organic condition such as syphilis of the nervous system, a brain tumor, an infectious disease, or a state of intoxication. Acknowledging the significance of the organic process, in these cases we speak of *organic psychoses*. (See *Organic Brain Disorders*) In many other cases—and this group includes the largest and often most crippling entity, schizophrenia—the significance of organic processes has not yet been established. This group is labeled the *functional psychoses*. In these cases we tend to speak of psychotic reactions. In other words, these psychoses are conceived as reactions to inner and outer stresses. Most theories presently held in the Western world fall into the third category. They make allowance for multiple viewpoints, but also have a focus of relevance, which gives them their characteristic bent.

What are the theories?

Taking the “focus of relevance” as our dividing criterion, six characteristic groups of theories may be outlined. They are:

a) *Theories viewing the psychoses as processes very much like physical disease processes*. Mental symptoms, in important respects, are treated much the same as physical symptoms. The emphasis is on the actual or presumed organic causes of the psychoses, usually located in the central nervous system. C. Wernicke, an earlier spokesman for this group of theories, said, “Mental diseases are brain diseases.” Many of the psychiatrists identified with these theories are trained in neurology. In large parts of Europe, South America, Japan, and Soviet Russia such organic theories of the psychoses prevail at present. (See *Biological Factors in Mental Illness*)

b) *Theories viewing the majority of the psychoses—mainly those called functional—as being highly determined by certain emotional and mental dispositions and personality structures*. In turn, these dispositions are often linked to certain body types or hereditary endowments. Ernst Kretschmer, for example, sees the leptosomic (*leptos*, fr. Gk. = thin, delicate; *soma*, fr. Gk. = body) body type as predisposing to schizophrenia, and the pyknic (*pyknos*, fr. Gk. = stout, compact) body type as predisposing to the manic-depressive psychosis. Similar views are held by William Sheldon and others in the United States. (See *Constitutional Variation and Mental Health*) Observations on many psychotic patients, particularly schizophrenics and manic-depressives, sug-

gest further that such dispositions might be inherited. F. J. Kallmann and others, studying many pairs of psychotic twins, lend support to theories that stress hereditary factors. (See *Heredity and Mental Health*) The problem is how to differentiate meaningfully the relevant traits and dispositions from environmental influences, which, as we know, greatly shape traits and dispositions during decisive developmental phases.

c) *Theories focusing mainly on the nature of the mental and affective processes occurring in psychoses.* These try to conceptualize the differences existing between psychotic and more normal mental structures and emotions. How, for example, can one compare psychotic delusions, hallucinations, flatness of affect (emotion), etc., to normal and neurotic phenomena? Theories focusing on this aspect of the psychoses, are often called phenomenological. More recently, under the influence of such existential philosophers and psychiatrists as Martin Heidegger, Ludwig Binswanger, Medard Boss, and others, a somewhat different phenomenological analysis of psychotic phenomena has developed. These theories, in a sort of encompassing analysis, try to grasp the characteristic psychotic "world design" or "mode-of-being-in-the-world." (See *Existential Therapy*)

d) *Theories evaluating psychotic symptoms and attitudes in the light of a person's adjustment to inner and outer stresses.* These theories, which include psychoanalytic theory, might be called dynamic. The psychotic symptoms denote adjustment failures as well as mental security operations; maneuvers allowing limited psychic functioning at the price of often severe interpersonal isolation and developmental arrest. For example, delusions, a prominent symptom in many psychotic, and particularly in schizophrenic patients, can give a certain inner cohesiveness to one's experiences, a certain sense of identity and self-worth. But this is achieved at the expense of great distortions of everyday reality. Inevitably, such a person is bound to have complicated and difficult relationships with others. The concepts of ego-weakness and regression derived from psychoanalytic theory figure prominently in dynamic theories. However, the psychotic regressions are uneven: functioning and nonfunctioning parts of the personality usually dovetail in complex and intricate ways. (See *Psychoanalysis*)

e) *Theories tying the psychotic symptomatology and experience to characteristic human relationships.* Most weight is given to the psychotic's early relationships with important figures in his life. Such theories might be called interpersonal. In the past decades much atten-

tion has been paid to the early infant-mother relationship. More recently, the whole family field in which a psychosis develops has been viewed as generating and reinforcing psychotic patterns. In these theories the nature and meaning of psychotic communications play an important role.

f) *Theories relating the psychoses to varying cultural values, attitudes, and religious beliefs.* These theories might be called sociological or cultural. Cultural factors, to an undetermined degree, are seen as shaping the form and content of many psychoses. In the United States, for example, many delusions reflect sexual preoccupations. On the Virgin Islands, Edwin A. Weinstein found, such sexual preoccupations seem to be replaced by concerns that have to do with children. Varying cultural attitudes toward sex and children are held to account for this difference. Ashley Montagu and others believe it is meaningful to view whole nations and cultures as suffering from, and participating in, psychotic behavior. The frenzied persecutory zeal of the Nazis, shared by the majority of a nation, may be seen as an example of a mass psychosis. (See *Culture and Personality*; *Social Anthropology and Mental Health*)

What are the various types of psychoses?

The functional psychoses include:

- a) schizophrenia
- b) manic-depressive psychosis
- c) paranoid conditions and paranoia (which some psychiatrists consider a subtype of schizophrenia)
- d) involutional psychoses
- e) a number of rare psychotic syndromes that are difficult to classify.

The organic psychoses include a variety of types, and are classified on the basis of the underlying organic condition. These include:

- a) psychoses associated with syphilis of the central nervous system (in this group belongs general paresis, which half a century ago was common, but nowadays is seen less frequently)
- b) senile and presenile psychoses
- c) psychoses associated with cerebral arteriosclerosis
- d) psychoses associated with brain tumors and other chronic neurologic disorders
- e) psychoses associated with epileptic disorders
- f) psychoses associated with acute and chronic alcoholic conditions

- g) toxic psychoses
- h) psychoses associated with a number of organic conditions such as head injuries, physical exhaustion, infectious diseases, encephalitis, and chorea (St. Vitus' dance).

How do the psychoses manifest themselves?

This varies greatly according to the type. Schizophrenia can manifest itself in a variety of subtypes known as the simple, the hebephrenic, the catatonic, the paranoid, or the schizo-affective. In schizophrenia we may observe an increasing apathy and withdrawal from other people, disorganized and "strange" thinking, a fragmentation of behavior, childlike silliness, seemingly unmotivated laughter and grinning, a tense rigidity possibly alternating with explosive outbursts, distrust, and a readiness to distort the meaning of other people's acts and motives. Any combination of these and other such features may occur. The onset may be gradual or sudden. In contrast to a number of organic psychoses, memory and basic intellectual capacities are often unimpaired in schizophrenia. Delusions and hallucinations, particularly the hearing of voices, are frequently prominent. (See *Schizophrenia*)

Manic-depressive psychosis manifests itself in spells of either elation or depression. During the intervals between such spells the behavior is usually normal. (See *Manic-Depressive Psychosis*) Involutional psychoses are most commonly characterized by depression occurring in the involutional period. Worry, intractable sleeplessness, guilt, anxiety, agitation, and delusional ideas are often present. (See *Middle Age*)

Paranoia, a disorder sometimes also called "paraphrenia," manifests itself in the growth of a delusional system that is often intricate and complex. (See *Paranoia*)

Organic psychoses often manifest themselves differently, depending, among other factors, on whether the associated organic condition is acute or chronic. In the acute disorders—also called acute brain syndromes—hallucinations, poorly organized transient delusions, and varying behavior disturbances can be observed. In the chronic disorders, disturbances of memory, judgment, orientation, comprehension, and affect may be marked and more or less permanent, depending on the nature and degree of organic impairment. (See *Alcoholism; Brain Damage*) Whatever the associated organic disorder, the psychoses will be colored by the way a person is accustomed to dealing with inner conflicts and stresses.

Who delineated the psychoses?

Up to the middle of the nineteenth century the psychoses were not differentiated from other mental disorders. William Cullen (1710–1790) is credited with introducing the term “neurosis” to denote the symptoms of an organic brain disease. Ernst von Feuchtersleben in 1845 called the organic disease itself the neurosis and its mental manifestations a psychosis. Emil Kraepelin, at the turn of the century, delineated a number of presumed specific psychoses, such as dementia praecox, manic-depressive psychosis, and paraphrenia (paranoia). He and other psychiatrists postulated specific material causes for these diseases, but, as mentioned earlier, thus far the search has been unsuccessful. Eugen Bleuler introduced the term “schizophrenia” to replace dementia praecox. Today Kraepelin’s classification of the psychoses is still accepted by most psychiatrists, although many do not share his postulating organic causes for all of them.

Who was prominent in the study of psychoses?

Since the psychoses play such a central role in psychiatry, almost any major psychiatric discovery has become relevant to their study. In addition to Kraepelin’s classificatory work, the specific contributions of Bleuler and Sigmund Freud to the study of the functional psychoses stand out. Bleuler offered a theory of schizophrenia, which integrated many relevant observations. In the center of his theory he placed the “looseness of associations” as leading to an impairment of orderly goal-directed thinking and behavior. Many schizophrenic symptoms could now be understood as either results of, or substitutes for, this basic disturbance.

Freud, particularly in his work on “Mourning and Melancholia,” threw light on the basic mechanism operating in the manic-depressive psychosis. Bertram Lewin, Melanie Klein, and others, have enlarged Freud’s insights. Further, in his work on the Schreber case Freud illuminated the dynamics of projection (attributing to other persons the unacceptable tendencies within oneself), a mental mechanism prominently employed in paranoid schizophrenia. (See *Mental Mechanisms*) His psychoanalytic insights laid the basis for the current development of ego psychology, which promises to further enlarge significantly our understanding of the psychoses. (See *Ego*)

In the United States Harry Stack Sullivan and Adolf Meyer have, from different angles, contributed to the study of the psychoses. Meyer became the proponent of an “overall” approach to the psychoses. Sulli-

van stressed and investigated the role of interpersonal processes. He tied psychiatry more closely to the social sciences. He gave new meaning to the concept of anxiety as it emerges in interpersonal situations and as it gives rise to psychotic symptoms and developments. Frieda Fromm-Reichmann, by engaging in long-term intensive psychotherapy with many psychotic patients, greatly increased our insight into how psychotic persons adjust to life and relate to others.

Philippe Pinel in France, John Conolly in England, Benjamin Rush and William Alanson White in the United States were pioneers in making the treatment of psychotic patients more humane. (See *History of Treatment of Mental Disorders*)

What is a psychotic?

A psychotic is a person suffering from a psychosis. This person is disturbed and in need of help, even though much of his behavior seems designed to push people away and to thwart any attempts to help him. In many respects our attitude toward the psychotic is a test of practiced humanity. Until rather recently the psychotics, in almost all parts of the Western world, were socially discriminated against, expelled from the community, and in all practical respects treated as criminals. For example, in 1804 it was reported that in the Berlin asylum "the most raving patients are, as long as their mad excitement lasts, confined naked in narrow boxes. Through holes in these boxes they are given their food in copper troughs which are chained." As late as 1842 an investigation of lodging conditions in Holland found patients "at night not seldom in chains, lying on dirty straw under one blanket, many without sufficient food, men and women mixed, and some who evidently had not seen daylight for a long time." These brutal measures reflect how threatening the psychotic's extreme distortion of reality, his confusion and loneliness, his tendency to uncontrollable aggressiveness and other forbidden impulses, must have been—and probably still are—to many people. However, progress has been made already in breaking down the wall of strangeness and otherness, which tends to be erected between so-called lunatics and normal people.

What is the difference between psychoses and neuroses?

This difference is thought of in various ways, depending upon the theory chosen. Generally it is held that psychoses are more severe, crippling disturbances than neuroses. But this does not hold absolutely. Some neuroses, particularly the obsessive-compulsive types, can be more

disabling and longer lasting than some psychotic states, especially when these are associated with some remediable organic condition. Many psychiatrists, particularly when subscribing to organic theories, contended and still contend that there is a qualitative difference between psychoses and neuroses. Neuroses are conceived as falling into the variety of human behavior that is accessible to common understanding, whereas the psychoses are not. Some authors talk of an "abyss" that separates normal and neurotic from psychotic behavior. In dynamic theories such qualitative difference is, as a rule, not upheld. The definition of defense mechanisms as permitting limited functioning at the expense of flexibility and personality growth applies to both neurotic and psychotic mechanisms. The difference is mainly that the more psychotic defense mechanisms result in a more massive break with reality than is the case with neurotic mechanisms. Freud believed that psychotic patients, because of their self-absorption, could not be reached through psychotherapy, and that neurotics could. But after the psychotherapeutic work that Sullivan, Frieda Fromm-Reichmann, and many others have carried out with psychotic patients, such a view is no longer held by many psychiatrists.

Are psychoses a symptom of another disorder?

They may be. The organic psychoses are cases in point. When, for example, syphilis of the central nervous system is successfully treated with high doses of penicillin, the psychotic manifestations, as a rule, will disappear. However, the relationships between brain disease and psychotic manifestations are often complex and elusive. The psychotic manifestations are not a simple reflection of damaged mental functions. They must also be seen as the person's characteristic defenses against the threat of disintegration, loss of self-esteem, etc., brought about by such impairment. This is particularly true in the case of the presenile and senile psychoses in which the mental impairment often seems to highlight a person's typical character traits and ways of solving conflicts. (See *The Senile Psychoses*)

What causes psychoses?

The causes are complex and, in many respects, still elusive. In a way, the notion of simple cause and effect is made problematical by the very study of the psychoses. Even where there seems to exist a relatively clear-cut cause-and-effect relationship, as is the case in the organic psychoses, this relationship, upon closer scrutiny, as shown in the preced-

ing paragraph, often turns out to be far from simple. This is even more true for the functional psychoses. As reflected in the different theories, a wide variety of causes, interacting in a complex way, must be assumed. Hereditary endowments, different temperaments, various processes affecting the body, interpersonal relationships, cultural values, prohibitions, and other factors can be seen as causes. In addition, characteristic types of psychoses will probably need to be more clearly delineated before the search for specific causes can become meaningful.

Can psychoses be produced experimentally?

Yes, they can. However, there is some doubt as to whether such experimentally produced states can be properly called psychoses. A number of drugs, of which L.S.D. (lysergic acid diethylamide) is the best known, can bring about states that in many respects resemble schizophrenia. For well over fifty years it has been known that juice from a Mexican cactus called peyote or peyotl can give rise to exceptional mental states, including changes in perception, emotions, thinking, and sometimes posture. An increasing number of such hallucinogens are being discovered and tested. Similar psychotic effects can be produced by extreme deprivation of sensory stimuli as J. C. Lilly, D. O. Hebb, and others have shown. The exact chemical and physiological processes associated with these psychotic manifestations are not yet known. However, it seems evident from these studies that a variety of stimuli are required to maintain a certain mental equilibrium. If the balance of stimuli is interfered with beyond a certain point, the resulting disturbance will reveal itself in psychotic symptoms. (See *Sensory Isolation*)

What effect do psychoses have on learning, productivity, physical, and social development?

Many psychoses severely handicap learning, productivity, and social development. Indirectly, by fostering unhealthy living and little exercise, they may also interfere with physical development. There are, however, great differences, depending on the type of psychosis, the age of onset, its course, and the personality of the psychotic.

Many psychotic developments can be described as vicious circles in which the lack of important skills, interpersonal as well as practical, maneuvers a person increasingly into a position from which a successful and productive life adjustment becomes more and more difficult to achieve. Defeat leads to more defeat, withdrawal to more with-

drawal. The impoverished life in the back wards of a state hospital appears often as the inevitable end result of these vicious circles. Such patients are usually diagnosed as chronic schizophrenics. They and other chronically psychotic patients represent the greatest loss of productive manpower due to any known group of illnesses.

Patients suffering from manic-depressive psychosis usually lead normal and productive lives in the intervals between spells. Many people suffering from schizophrenia do not become chronic and again become productive. The relationship of the psychoses to genius and uncommon artistic and literary productivity is still elusive. A number of outstanding writers and artists have been psychotic; for example, Edgar Allan Poe, August Strindberg, Friedrich Nietzsche, and Vincent van Gogh. (Nietzsche most likely suffered from general paresis, Poe from manic-depressive psychosis, Strindberg and van Gogh from schizophrenia.) It is argued that creativity and some psychotic processes are interrelated in that both imply a release of normally inaccessible inner experiences and motivations. Though this may be so, the fact remains that in one case such release of unconventional experiences leads to creative mastery, whereas in another it leads to incapacitating fragmentation. Although both may be exposed to similar conflicts, the creative artist and the psychotic certainly differ in their manner and ability to cope with these conflicts. (See *Creativity*)

Is there a particular age when psychoses are likely to manifest themselves?

Psychoses in childhood are rare. The hebephrenic (*hebes*, fr. Gk. = youth; *phren*, fr. Gk. = mind) and catatonic types of schizophrenia often become manifest during adolescence and in the twenties. Paranoid developments frequently occur in the thirties and later. Manic-depressive psychosis occurs in all stages of the adult life. The involutional psychoses, as implied in their name, characteristically manifest themselves in the involutional period. The presenile and senile psychoses befall elderly persons.

Are certain groups more susceptible than others to certain psychoses?

The important functional psychoses—schizophrenia and manic-depressive psychosis—seem to be fairly equally distributed among the sexes. Involutional psychoses are more frequent in women. A somewhat uncommon type of psychosis, called postpartum psychosis, occurs in women after delivery of an infant. It has been estimated that the

incidence of schizophrenia is approximately one per cent of the total population or 40 to 60 per cent of the admissions to psychiatric hospitals, while the manic-depressive psychoses contribute 10 per cent to these admissions. A recent comprehensive study by August B. Hollingshead and Frederick C. Redlich on *Social Class and Mental Illness* suggests that psychoses are significantly more frequent among groups of lowest income and social status. The reasons are unclear. A number of studies suggest also that social groups that are under great pressure to change, such as low-status Negroes trying to conform to middle-class values, are more susceptible to certain psychoses than are other social groups. Studies on the incidence of psychoses in industrialized cultures versus more primitive ones are still too inconclusive to warrant general statements. (See *Social Status and Mental Health; Social Change and Mental Health; Mental Disorders in the United States*)

Are normal fears and anxieties ever confused with psychoses?

Generally they are not. However, there are certain border situations when a person, shaken by an unexpected event like sudden disaster or loss of a close relative, may "lose his mind" in a way that might suggest a psychosis. Concern is usually unwarranted. The rapid biological and psychological changes that are part of adolescence sometimes precipitate states of "identity diffusion," characterized by confusion and feelings of "unrealness" (depersonalization). These and similar states may not easily be differentiated from more serious schizophrenic developments. Also, there are transitions from relatively light and normal mood swings to the severe spell typical of a full-blown manic-depressive psychosis. More recently it has been noticed that families with a schizophrenic member can be unusually blind to disturbances in each other even though such disturbances may appear flagrant and conspicuous to an uninvolved person. (See *Identity; Adolescence*)

What treatments are available for psychoses?

Along with the division of theories into more organic and more dynamic ones, two main groups of treatment have evolved: first, organic therapies, including insulin and electroshock therapy, lobotomy, and various medications (particularly with tranquilizers); and second, psychological treatments, including intensive psychotherapy, group therapy, family therapy, and the management and supervision of the milieu and life-situation of the psychotic. Combinations of these various forms of treatment are often practiced.

The modern treatments along organic lines received an impetus from Julius Wagner von Jauregg in 1917, who proved that malarial therapy could "cure" general paresis. M. J. Sakel in 1933 began to treat schizophrenia by inducing insulin comas. L. J. Meduna in 1935 used Metrazol (pentamethylenetetrazol) as a convulsant for the same purpose. Electroshock was introduced in 1937-1938 by U. Cerletti and L. Bini. It is now widely practiced. Lobotomy, introduced by A. Egas Moniz and L. Lima in 1935-1936, consists of an operation on the frontal lobes of the brain, which is carried out in various modifications. (See *Psychosurgery*) During the last fifteen years tranquilizers such as chlorpromazine (Thorazine) have been increasingly used. Unfortunately, none of these treatments proved to be an overall remedy. Electroshock seems most effective in depressive reactions and in middle-aged persons. To some degree the tranquilizing drugs have revolutionized hospital and outpatient clinic practices. Many psychotic patients, who previously required continuous hospitalization, can now be maintained on drugs outside hospitals. Also, in lessening the disintegrative impact of the psychotic anxiety, these drugs make many patients more amenable to psychotherapeutic and rehabilitative measures. (See *Psychopharmacology*) The individual intensive psychotherapy of psychotic patients, aimed at a lasting personality change, unfortunately requires an investment of therapeutic time and skill that makes it presently unavailable to the great majority of psychotics. (See *Psychotherapy*) Group therapy, frequently in conjunction with some organic therapy, is now available in many psychiatric hospitals. The increasing use of social service facilities and family therapy and counseling has helped many psychotic patients to return to a productive life in the community. (See *Group Psychotherapy*; *Family Psychotherapy*)

Based on current research, what might be predicted about the prevalence, degree, and treatment of psychoses in the near future?

Never before in the history of this country and the Western world has there been so much interest in the psychoses. We can expect that a heavy research investment together with a changing public outlook on the psychoses will soon throw light on many problems that are still elusive. Together with these developments, the prevention and treatment of the psychoses will become more successful. Two areas of research appear to be particularly significant: the study of families in which psychoses develop, now being done in various centers in this country, and the expanding science of psychopharmacology, which is

perhaps best equipped to make us see the enormously complex interplay of interpersonal, intrapsychic, and organic processes. Further, a better understanding of the processes of acculturation, of personality growth and its dependence on innumerable factors, inevitably will result in better understanding, prevention, and treatment of the psychoses. However, we must be aware that the psychoses, in a way, will remain most resistant to intervention because in them we find reflected man's most frightening potentialities: loneliness, disintegration, destructiveness. It is easy to trivialize this aspect by expecting merely that more research and plans for treatment will remedy deep problems of human existence that seem elusively hidden under the name psychosis. (See *The Family in Illness and Health*; *Psychopharmacology*)

PSYCHOSEXUAL DEVELOPMENT IN MAN

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What are the earliest signs of activity of the sex organs?

The first activity of the sexual organs appears in the newborn. Some girl babies have a slight amount of menstrual bleeding in the first few days of life, caused by separation from the influence of the mother's estrogenic hormones (normal adult menstruation occurs at that point in the female cycle when estrogen is replaced by progesterone).

In boy babies, erection of the penis occurs spontaneously as early as the first day of life. It occurs apparently in a mechanical sort of way in response to genitopelvic stimulation, including bladder tension, or to generalized body tension, and as part of a generalized emotional reaction. Only later in life does erection become triggered chiefly by stimuli that are erotically arousing. Infantile erections usually do not lead to climax. It is quite possible, however, according to the observations of Alfred C. Kinsey, for baby boys, even before they are a year old, to exercise their bodies and genitals rhythmically to the point of showing visible signs of sexual climax, minus ejaculations. Female babies can also show spasmodic muscular contractions and other physiological signs of sexual climax, but such occurrences are rare in babies of either sex.

It is also possible for babies and infants of both sexes to experience something that must be akin to pleasure and comfort from petting of the sexual organs. It is customary among some people to use stroking and playing with the genitals as a method of quieting fretful infants and putting them to sleep. From the earliest age, therefore, the sexual organs transmit feelings of the type that in adulthood will be readily identifiable as sexually pleasurable.

What is the psychological significance of sex organ activity in infants?

Newborn babies, when put flat on their bellies, make swimming or crawling movements. When supported at the shoulders in the upright

position, they make treading movements with their legs. Even at so early an age the muscles and nervous system are capable of making such locomotor movements, but still the baby can neither crawl nor walk. It requires further maturation and experience of the organism before the early movements can be put together into the coordinated patterns of crawling or walking. For example, the body must mature to a stage where the head can be properly supported, before crawling or walking can be accomplished.

In sex as in locomotion, it appears to be nature's plan to develop part-functions in advance of the time when they will be assembled into a complete pattern and put to full use. Some of the part-functions are already intact at birth. Others, including psychological part-functions, become established in the course of infancy and childhood and gradually become assembled into the master pattern. By the age of about seven or eight, a child is capable of nearly everything, sexually speaking, of which he will be capable as a teen-ager and as an adult. Fertility and glandular secretions will be added with the advent of puberty, and so will the capacity for that special psychological event known as falling in love. The hormones of puberty will also add to the urgency, frequency, and intensity of sexual urge or desire. What puberty adds to the sexual development of an eight-year-old can actually be observed, in a few instances, in children who begin their pubertal development as early as eight, or even earlier.

On what principles do psychosexual maturation and differentiation take place?

Maturation of the locomotor system, the respiratory, circulatory, and most other systems can be discussed simply as a differentiation from less to more mature. Psychosexual maturation can be considered also on this same gradient, i.e., from newborn to adult. Simultaneously, however, psychosexual maturation entails a differentiation into masculine and feminine.

Before looking further into male-female psychosexual differentiation, it will be interesting to look at nature's plan in bringing about differentiation of the sexual anatomy. Actually, there are two principles, one for the gonads (the ovaries or testes) and internal reproductive structures, the other for the external organs. Internally the principle is to produce everything in hermaphroditic duplicate, the anlagen (rudimentary beginnings) of the male organs alongside those of the female, irrespective of whether the baby will be a boy or girl. Then, one set of structures proliferates while the other atrophies. Thus, if the kind of

the primitive gonad grows and proliferates at the expense of the core, the gonad becomes an ovary. If the opposite happens, the gonad becomes a testis. Again, if the pair of Wolffian ducts atrophy and the Müllerian ducts proliferate, a uterus and tubes are formed. Otherwise the Müllerian ducts atrophy and the Wolffian ducts become the appendages of the male testes. In adulthood, remnants of the atrophied structures remain, and can be seen when examined under the microscope.

Externally the principle of differentiation is to produce homologous organs from the same precursor organ. Thus the genital tubercle becomes either a penis or a clitoris. The skin that wraps around the penis and fuses along the midline to make the penile urethra is embryologically the same as the skin that makes the hood of the clitoris and the labia minora. The skin of the scrotum corresponds, unwrinkled and unfused, to the labia majora.

Whether the one or the other principle might be a paradigm for psychosexual differentiation is conjectural. In psychosexual theory, it has long been fashionable, however, on the analogy of the principle of internal differentiation, to postulate an innate psychological bisexuality of the human organism. The proper analogy to be drawn—and equally well from both principles—is not an innate bisexuality but an original state of undifferentiation. This may be resolved either way, as experimental intervention has shown. Usually it proceeds as male or female under chromosomal regulation. Differentiation, except in unusual cases of congenital sex-organ defect like hermaphroditism, is complete, unambiguous, and irreversible.

The psychological study of cases of hermaphroditism and related sex-organ deformities has shown that psychosexual status at birth is undifferentiated. In the case of certain of these deformities it happens that some of the infants are assigned and reared as boys while others, with the same diagnosis, are assigned and reared as girls. Then the gender role and gender identity develop and become established according to the rearing, in the majority of instances, particularly if the rearing is thoroughly consistent, if the external genitals either are not grossly incongruous in appearance or have been surgically reconstructed, and if the secondary sexual development of puberty is appropriately regulated by hormonal therapy.

Psychosexual differentiation is, therefore, not automatically predestined by factors existent prior to birth, but is dependent on, and extremely responsive to, events in the personal history after birth.

What is the relationship of psychosexual differentiation to other variables of sex?

Formerly it was widely taken for granted that psychosexual differentiation and development proceeded as a sort of biological unfolding, somehow dependent on genes, chromosomes, and hormones for sex differences. The sex differences, according to this point of view, were considered innate, constitutional, and instinctive. Cultural anthropologists and sociologists discovered the error of this early biology. They found that the psychological criteria of the masculine and the feminine may vary radically from one ethnic group to another. (See *Culture and Personality*)

The number of sexual variables that may be independent of one another became evident from the study of hermaphrodites. These variables are seven, a group of five and a group of two. The first group consists of:

- 1) chromosomal sex, or sex of the cell nucleus
- 2) gonadal sex
- 3) hormonal sex and secondary sexual characteristics
- 4) external genital morphology
- 5) internal reproductive structures

The second group consists of:

- 1) sex of assignment and rearing
- 2) gender role and identity established while growing up

In the normal course of events, all seven of these variables are congruous with one another. In hermaphroditism, one or more of the first five may be incongruous with the sex of assignment and rearing, with the latter being the influential one in determining the gender role and identity as male or female. Gender role and identity itself may be independent of all the other six, as in homosexuality and eonism (transvestism—sexual pleasure derived from dressing or masquerading in the clothing of the opposite sex).

Psychosexual differentiation as male or female may proceed incongruously with one or more, or even with all six of the remaining variables of sex.

Prior to male-female psychosexual differentiation, how does psychosexual maturation begin?

Sex is not simply the sexual organs, and sexual activity is not simply copulatory insertion and reception. All the senses—seeing, hearing,

smelling, tasting, and feeling—become involved in a complete act of lovemaking, but the arousal and participation of the whole body is chiefly through the somesthetic sense—through the sensations and feelings of the different organs as they go into action or are acted upon. Thus kissing is sexual—intensely so for some people—as are stroking and caressing, and so forth. These somesthetic components of a complete act of lovemaking are already functionally intact in early childhood. They are another example of part-functions that do not become coordinated and patterned into the whole until later.

It was psychoanalysis that first recognized the significance of these somesthetic components of eroticism in infancy. The proper exercise of these infantile part-functions is fundamental to the proper development of mature erotic function and, indeed, even more widely to the normal development of personality in its entirety.

Following the lead of psychoanalysis, the usage is now widespread of referring to the first pregenital stage of psychosexual development as the oral stage. Here the emphasis is on the fact that the child feeds by sucking, that his mouth brings him into close, snuggling contact with the mother, and that both experiences bring gratification.

Actually, snuggling and nestling close to the mother is even more basic than suckling, according to the observations of René A. Spitz on the impaired growth and development of institutionalized infants who are properly fed but deprived of cuddling and fondling. H. F. Harlow, in a series of experiments at the University of Wisconsin on baby macaque monkeys, found even more remarkable information on the importance of clinging and snuggling in infancy. Harlow reared orphaned monkeys on dummy mothers. Some of the dummies were covered with a shaggy-weave toweling, and some were only uncovered wire frames. Whether the dummies had faces or not, supplied milk or not, or were warm or not was unimportant. The all-important difference was the cloth covering. The babies had to be able to cuddle, snuggle, rub, and cling in order to grow up behaviorally normal. Interestingly enough, however, even the babies with cloth mothers grew up sexually impaired at adolescence compared with monkeys reared by live mothers.

The first stage of psychosexual development might, therefore, more properly be called not oral but haptic, in reference to the feelings and sensations of being touched, held, and cuddled close to the mother, and not only for suckling.

Is the beginning of psychosexual maturation instinctive?

The original Freudian conception of psychosexual maturation was that all three stages, oral, anal, and genital, were manifestations of the libidinal driving force or instinct. The original Freudian conception of an instinct was of a driving force seeking an outlet. More recently, the school of ethologists in animal behavior has directed attention to the importance of certain perceptual sign stimuli in triggering certain instinctive patterns of behavior. The now famous example, discovered by Konrad Lorenz, is that a squat-shaped, moving object triggers the following behavior in newly hatched ducklings: If no moving object is presented within the first day or two of life, the ducklings never establish the habit or "imprint" of following (normally, of course, they follow the mother). But any moving object will do, provided it is not too big, too tall, or too horizontal. There are phylogenetic limits to what may constitute a suitable stimulus, but within those limits remarkable variety is experimentally possible. Even more remarkable is the fact that once a particular moving object is imprinted as the one to follow, then that object alone is followed for the duration of childhood, or longer.

The attachment of Harlow's baby monkeys to their dummy cloth mothers can be analyzed in terms of imprinting, although Harlow did not so do. In fact, the behavior of many baby mammals toward their mothers, and the accuracy with which they identify their mothers in a herd, is probably a matter of imprinting to smell as well as to sight or touch. The imprinting concept can be applied also to certain types of human learning, even though such imprints may be more flexible and modifiable than in some species. Human babies are rather like monkeys in needing a cozy surface to nestle up to. For example, many infants get imprinted to a special piece of fuzzy fabric that they press against the mouth and nose while sucking the thumb or finger like a nipple in order to go to sleep. Although such imprints are not necessarily harmful, and may be more beneficial than no imprint, they almost certainly are never a perfect substitute for an imprint to the feel, taste, and smell of a real live mother, and later to the sight of her.

What is the second stage of psychosexual development?

It is a familiar observation that a post or tree trunk has a special value as a sign stimulus to trigger sexual scenting plus urinary behavior in a dog, and also that a patch of pebbly or sandy soil is a good stimulus

for defecation followed by kicking movements of the hind legs to pile up soil on top of the feces. Cats also react to sandy soil for both urination and defecation, but they scratch a hole first and cover it over afterwards. In both animals there is a critical time in infancy when, after indiscriminately messing the nest, they become capable of forming an imprint to the appropriate sign stimulus and of establishing excretory cleanliness. It is at this point in the life history that the sign stimulus may be varied, as it is in housebreaking a cat, for instance, that is trained to excrete on a sheet of newspaper, or even down the bathtub drain. Or a dog may be trained to imprint cement and asphalt outdoors, but not the floors of a house, as a place on which to excrete. Then one sees the city dog hunting round, in the same persnickety manner of a rural dog, for just that certain place that will release his sphincter.

Human beings are more like dogs and cats than cows or horses in their capacity for becoming imprinted to certain perceptual objects as places for excretion. The critical period for the emergence of this capacity is after a sitting posture can be achieved, usually in the second year of life. Some children acquire toilet training themselves almost unaided, especially if the necessary apparatus is made accessible at the critical age period.

The development of voluntary control of the sphincters of elimination is a great achievement, and carries its own pleasure and reward of the joy of achievement, like other milestones of growth such as competence in visual fixation and auditory discrimination, locomotion—crawling and walking—and talking.

Sigmund Freud, with his attention directed to libido and the pleasure principle, used the developmental milestone of anal sphincter control as the mark of his second stage of psychosexual development. It would have been better had he considered the anal stage one of the milestones in general personality development rather than more narrowly of psychosexual development. Anal functions are not important components of adult eroticism, as are oral and haptic functions, except when defecatory and psychosexual development go wrong and when erroneous connections are made, and become distorted, as in the sodomist, or the person whose sexual pleasure becomes connected with watching defecation, being defecated on, or eating or smearing feces, and similar pathologies. Perhaps the taboos common to both sex and excretory organs in child rearing have something to do with subsequent anal-genital substitutions and displacements. (See *Psychoanalysis*)

What are the broader personality correlates of the psychosexual stages?

Erik Erikson is one of the modern psychoanalysts who has formulated a scheme of the broader personality patterns being laid down at each stage of psychosexual development. For him the key to the first stage is that this is the time, during the first year, when a basic sense of trust or mistrust is developed in the mutual relationship with the mother, later to pervade relationships in general.

The key to the second stage, the anal stage of the second and third years, is that this is the time when a basic sense of autonomy develops versus a sense of shame and doubt. Erikson, like other psychoanalysts, recognizes a connection between experiences related to toilet training and subsequent neurotic distortions of personality. For example, there is the well-known overcompulsively clean and orderly type who is stingy, retentive, and meticulous, not only in matters concerning his bowels, but also in matters of affection, time, and money.

After the anal stage, Erikson recognizes, in the genital or oedipal stage, a phase of development in the fourth and fifth years characterized by the establishment of a sense of initiative versus guilt. For the remainder of childhood the fourth stage ensues, during the so-called latency period, characterized by the development of a sense of industry versus a sense of inferiority. With adolescence comes a fifth stage, development of a sense of identity versus a sense of identity diffusion. (See *Child Development; Personality*)

When does male-female psychosexual differentiation begin?

In classical Freudian psychology, it is with the advent of the genital phase in the fourth year that boy-girl differences begin to appear in psychosexual development. In point of fact these differences begin to appear as early as the eighteenth month, with a period of specially intense differentiation in the fourth and fifth years, the so-called oedipal period. The Freudian psychosexual stages are really not stages at all in the sequential sense, but overlapping periods in each of which a special facet of development is taking place.

The fact that gender differentiation in psychosexual development begins to take place as early as the age of eighteen months was made apparent from the study of children with sex-organ deformities. As mentioned previously, it is possible for children with the same deformity and the same diagnosis to be raised some of them as boys, some as girls. Then the usual consequence is that they develop psychosexually according to the sex of assignment—according to the sex of the haircut.

When one sees two such children side by side, it is in the latter half of the second year of age that boy-girl differences in behavior begin to appear.

The emergence of these differences coincides with use and understanding of language that clearly differentiates male from female, especially in the pronouns. At the same time, a child is perceptually able to grasp the difference between the sexes in clothing and cosmetics, as well as in physical countenance and voice. In a household where nudity is not forbidden, a child at this age can also grasp the significance of the different sexual appendages, notably breasts and penis.

It is probably no accident that the human race virtually everywhere has sex-different styles of clothing and haircuts. If you want to know how dependent you are on these cues, especially at a distance, make a cutout that will hide clothing and hairstyle in magazine photographs, then guess the sex of the figure. You will be fooled many times, just as an audience can be fooled by a female or male impersonator. The importance of giving people the correct cues so that they will treat a child correctly is recognized even for the infant, with pink for girls and blue for boys.

How does male-female psychosexual differentiation proceed?

A human baby ordinarily is born with all the neural machinery for becoming proficient in speech, but he is not born with a language, nor with the prototype of a language that will appear of its own accord. His language becomes established only after exposure to the perceptual stimulation of a language in use in the environment. Under these conditions, the child's language becomes modeled after that of his environment or, one might say, the language he hears becomes a sign stimulus to which his own linguistic responses become imprinted. It is practically impossible to prevent a child from learning to talk. Communication is its own reward.

Establishment of a gender role and gender identity as boy or girl apparently takes place in much the same way as the establishment of language. A baby is born with all the neural prerequisites for identifying with and impersonating another person to whom he is exposed. The stimulus that triggers the copyist behavior of identification and impersonation can be any person in the immediate environment, most usually one of the parents. It is well known that at kindergarten age the child's model can be a representative of any dramatically interesting profession or trade—fireman, nurse, soldier, teacher. And, of course, young children are forever playing mothers and fathers.

The fact that hermaphroditic children of the same diagnosis grow up to have a gender role and identity in agreement with their rearing suggests that anatomically normal boys and girls can be equally responsive to either a male or female stimulus figure as the sign stimulus to which their gender-copying responses become imprinted. What happens in the ordinary course of affairs is that pressures and rewards, both subtle and obvious, steer the boy infant to get imprinted to a male, usually the father, and a girl to a female, the mother, as the model from whom to pattern his or her own gender specific behavior.

The critical period for the imprinting of gender role and identity is between the ages of approximately three and six. By three, children are likely to be very inquisitive about identifying sex differences, and playfully exuberant about exhibiting what they have identified themselves to be.

There are authentic clinical records of boys who began to show effeminate behavior before the age of four. Moreover, in the study of hermaphrodites given a reassignment of sex, it has been found that reassignments can be made without psychological harm to the child up to a year of age, provided the parents are properly prepared and guided through the upheaval. Following the end of the second year, however, after the child begins to have a command of language, a change is psychologically hazardous. Later on, individual evaluation may reveal that a hermaphroditic child's gender role and identity is already developing not in accordance with, but contrary to, the sex of assignment. Otherwise a sex reassignment is best avoided as too risky—too likely to be psychosexually a failure and too likely to lead to general psychological maladjustment.

Some adults, hermaphroditic and anatomically normal, request a reassignment of sex legally, with surgical and hormonal corrections. These cases demonstrate how profoundly the gender role and identity can become imprinted contrary to the sex of assignment and rearing. Most members of the human race become correctly gender imprinted, however, in the way that matches their reproductive capacity. This imprint is so indelible and irreversible, that mankind intuitively thinks it to be an instinct, innate and independent of postnatal experience.

What is the Oedipus complex?

The subtle and profound interplay that exists between the members of a family, notably between the child and his parents, during the imprinting of gender role and identity in early childhood is now commonly known as the oedipal situation.

Describing the triangular relationship of parents and son from the son's point of view, Freud named this interplay the Oedipus complex. Oedipus was the son of Laius and Jocasta, king and queen of ancient Thebes. Because of an oracle foretelling that Oedipus would kill his father, he was given at birth to a herdsman to be exposed to the elements. His life was spared and he was adopted by the king of Corinth. When grown he left Corinth. In battle he killed the king of Thebes and married his queen. When he discovered that the woman was his mother and that he had fulfilled an oracular prophecy, he blinded himself.

In this ancient legend Freud saw the embodiment of a developmental fantasy that he attributed to the unconscious of all male members of the species. Today in psychoanalytic theory the Oedipus complex is viewed largely not as a biological universal, but as an occurrence that varies from one ethnic cultural group to another, and even from one family to another, dependent on the nature and quality of the interpersonal relationship that the parents have to each other and that each has to the growing child. For example, the oedipal relationships will be quite different in a happy, mutually trusting family than in one where the parents yell and scream in bitter violence at one another, never have sexual intercourse, and use the boy as a pawn, the father catering to him by sleeping in the same bed with him and buying him dolls, and thereby managing to provoke his wife to a fury of invective.

Although the oedipal legend refers to a male, it is now common in psychoanalytic usage to apply the term, "oedipal situation," to a girl's as well as a boy's psychosexual differentiation. In the case of a girl, she identifies with the mother and simultaneously, thereby, becomes a competitor for the father's attention and affection. The obverse holds for a boy.

A by-product of this rivalry, in classical Freudian theory, is fear of punishment or castration anxiety in boys, which in girls becomes penis envy. Another by-product, secondary to internalization of imposed restraints and vetoes, is growth of the superego. A possible by-product of oedipal rivalry, overlooked in classical analytic theory, is barrenness anxiety in girls. The counterpart in boys is pregnancy envy.

What is some of the early behavioral evidence that correct male-female psychosexual differentiation has taken place?

The observant person can see ways that the child of three or four is a chip off the old block. The girl has feminine ways and mannerisms,

in posture, behavior, and talk, borrowed directly from her mother, grandmother, grown sister, or other significant female in the household. And obversely for the boy.

Around the same age, it is often easy to see a little girl being outrageously flirtatious in a cute and beguiling way around men. She can wheedle and cajole her father in a way totally impossible for her brother, with whom he is more stern. She is father's girl; and he likes the attention as much as she laps up the indulgence he bestows. The boy, on the other hand, has a special place in his mother's heart and knows that he can always find a soft spot there when life has been too tough or father too strict. He enjoys a chance to play the man's role, and does it well sometimes, as when he escorts his mother on a shopping expedition. It is not at all uncommon to hear a preschool boy declare that he will marry his mother when he grows up, and a girl her father.

Play is the medium par excellence through which children show their developing gender role and identity. Many forms of play are stereotyped as belonging to boys or to girls, usually because they are replications in play of the gender-specific occupations and activities of adulthood. Girls play at baby care with dolls, boys operate toy cars and trucks, and so forth. It is the predominance of the play interest that counts. A single deviance is no necessary cause for alarm. Moreover, the stereotypes do not always hold. For example, girls play house. But the boy who joins them to be the father is within his gender role. The boy who does raise cause for alarm is he who constantly organizes games of house and plays other than masculine parts. Again, with dolls, there is a big difference between the four-year-old boy who has a girl doll and plays mother to it, and the one who has a boy doll to which he plays father.

In earliest play, one of the big disparities of our culture pattern is already apparent, namely, that it is much more acceptable for a girl to be boyish than for a boy to be girlish. This disparity carries over into sport, clothing styles, and eventually occupation. It is legitimate, therefore, to be more laissez-faire about tomboyishness in girls than sissiness in boys—and thus to perpetuate the disparity.

A good deal of childhood play, like childhood fantasy and dreams, has the function of being a rehearsal and preparation for the future. One may say, indeed, that it is as integral a part of nature's plan to rehearse psychosexual part-patterns in advance of the time when the total pattern of maturity will cohere, as it is for genitopelvic part-func-

tions to be operative long before the total function of maturity is co-ordinated. (See *Play, Recreation, and Mental Health*)

What genitopelvic sexual behavior is seen in the preschool child?

There are extremely varied individual differences among children and equally varied differences among the peoples of the world in their child rearing practices. Peoples range all the way from strict suppression to amused approval of childhood sexual experimentation. Inevitably, therefore, the genitopelvic sexual behavior and play of children varies greatly in time and place. It follows that there is great variety in what can be considered typical or normal. A good rule of thumb is that a child who deviates too greatly from the standards and customs amid which he grows up is one who needs attention.

In our own society, genitopelvic sexual behavior in the presence of adults is generally reproved, so that most infants rapidly learn to inhibit such behavior or at least to keep it from view. Nevertheless, it is reasonably common to find that babies, as their motor coordination develops, begin playing with their own genitals in the same way that they play with fingers and toes. They may also discover how to make rocking, rubbing, pressing, or swaying movements that stimulate the genitals. It is desirable not to make a big event out of such behavior by exaggerated attempts to curb it. The parents who take an easygoing attitude, neither foolishly permissive nor fanatically corrective, are the ones whose children's genital habits fall into proper perspective and do not become a social nuisance or a pathological obsession. Masturbation may continue to occur sporadically throughout childhood, but it may also be practically nonexistent.

Around the age of three, children are likely to go through a phase of investigative curiosity, discovering how boys differ from girls and how they personally compare genitally with other children. They also display what they have discovered themselves to be, with the same pride of ownership with which a new owner displays his car.

There is considerable interest among little girls in the urinary prowess of little boys, with a girl sometimes going through a period of insistence that she too can stand to urinate.

The sexual play of the preschool years may include the make-believe of protruding with pregnancy, especially in families where the mother actually is pregnant at the time, and similarly with breast-feeding.

Where household nudity is not strictly tabooed, children's curiosity

extends to the sexual insignia of adulthood, notably breasts and hair, and they may ask questions about them.

What is advisable concerning household nudity?

The stronger the household taboo on nudity, the more it is necessary for children to discover sex differences surreptitiously. It is therefore a good idea for children to be able to see nudity on occasion within the family in a casual, informal way. Nudity can be overdone, just as prudery and too much modesty can be overdone. Somewhere in between is the middle of the road that enables a child to be casual about nudity, as discretion demands, but also appropriately conformable to customs of modesty.

What is advisable concerning modesty?

Children achieve middle-of-the-road equilibrium only after they have zigzagged from side to side. Thus, as a counterpart to peeping and showing themselves, preschoolers have periods of modesty and periods when they demand privacy. There are inconsistencies. The four-year-old makes an elaborate production of not being seen in the bathtub, but then prances stark naked through the living room to get the forgotten bathrobe.

Guidance is necessary not only with respect to the immodesty of peeping and showing, but equally with respect to excessive modesty and prudery. Fanatical modesty and a phobia of being seen naked, apart from hampering medical care, may severely limit or even destroy sexual functions in adulthood. Some people cannot have intercourse unless clad. More extremely, there are some whose pathological modesty prevents sexual arousal in the presence of a partner. They are frigid or impotent instead, somewhat like the people who cannot release urine or feces if anyone is watching.

The child's task in growing up is to achieve a middle course between excessive conformity and excessive nonconformity to customs and social rules regarding nudity and modesty.

What is advisable concerning sleeping arrangements?

There are societies where copulation may sometimes be seen by children, for example, among primitive peoples who have no privacy of sleeping quarters. Play at the three-to-five-year level in such a society may include mimicry of copulatory activity, such play being acceptable within the customs of that society.

The customs of our own society taboo tolerance of copulatory play in children. These same customs also taboo children's witnessing of adult copulation. Under these circumstances, it can easily be psychologically injurious for children to experience breaking of the taboo against witnessing copulation—the "primal scene" in the language of psychoanalysis. In general, this means that after the newborn period it is better for a child to sleep away from the parents. This arrangement is also less inhibiting for the parents.

To allay anxiety from night fears, young children sometimes need to get into their parents' bed. Far into childhood there may be a sort of nesting comfort at being able sometimes to share the parental bed, perhaps tinged with a tingle of oedipal victory. In general, however, where the family income permits separate sleeping quarters, it is more harmful than helpful to permit a child sleeping with a parent. Serious psychological problems arise when an estranged, divorced, or widowed parent has a child, especially one of the opposite sex, sharing the bed routinely. The older the child, the more serious the problem.

Whether siblings sleep in the same bed or not depends ultimately on family finances. Problems of heterosexual or homosexual bed play seem not likely to arise before the age of five or six, and after that they may or may not. Separate beds do not necessarily eliminate such occurrences nor necessarily discourage them, but separate sleeping accommodations assist children to obey the incest taboo, which is universal and nowhere more powerful than in our own society. Because it is such a powerful taboo, any transgression is likely to have severely adverse consequences, especially because of the way other people react. (See *Parenthood and Child Rearing*)

What is the desirable extent of sexual knowledge in early childhood?

The principle that governs the giving of sexual knowledge to children is that sexual knowledge of some kind will be picked up, pieced together, or guessed by any child who is not proverbially deaf, dumb, blind, and silly. Therefore, it is logical and sensible to supervise the imparting of sexual information in order to guard against errors of fact, conviction, or emotional attitude. The so-called perversions and sex behavior disorders have their origins in childhood. One way to help ensure that they never begin is to provide a child with simple, unequivocal knowledge of the facts of reproduction and the role of the two sexes.

The timing of sex education differs according to intelligence and also

to circumstances that arouse curiosity. A bright three-year-old whose mother is advanced in pregnancy will need information more punctually than a child who is not about to get a brother or sister.

It is easy to tell even three-year-olds about the baby nest inside the mother where the baby grows. At three, this amount of information may be enough for a single occasion. It is not necessary to tell everything at once and produce mental indigestion. Questions at age three and four often sound profoundly philosophical and abstract—questions about birth, death, God, and the universe. Though about profound issues, these questions are best answered briefly, nonabstractly, and operationally. "How does the baby get out?" a four-year-old asks, and he is entirely satisfied with: "Through the baby tunnel." A baby chute, one youngster called it. Some children will immediately request more information, which others would find extraneous and confusing. These others will absorb the further details better at a later date.

Even the sunplest information will have to be imparted more than once, to refresh the child's memory as needed. This is the age of repetition, well evidenced in the joy of repeating nursery stories and rhymes. It is also the age when something may need to be told half a dozen times before it fully makes sense and fits coherently into place in the larger scheme of related knowledge.

It is a good idea for both the father and mother to be equally adept and at ease in talking about reproduction with either sons or daughters.

After the concepts of baby nest, egg, and tunnel are operational, the next installment, the story of the swimming race of the sperms can be introduced: two hundred million of them and only one wins! Children love that bit of drama. The prize is to join with the egg and make a baby. You can make drawings and use the diagrams in sex education books.

Sperms are made by the father in the sperm factory of the testicles, and swim out of the penis and up the baby tunnel. Depending on how squeamish you are, you might or might not eventually find the time opportune to explain the mechanics of insertion of the penis into the vagina.

Menstruation can be explained as nest-cleaning day. Explained in this way, menstruation can be anticipated as a badge of womanhood and accepted as an ordinary body function when it appears, minus nightmarish anxiety about bleeding to death. It is similarly a good idea

for boys to know in advance of time about the white sticky fluid the sperms swim in and are nourished by. Then the first ejaculation or first wet dream is encountered as an expected, routine function. (See *Menarche; Menstruation and the Sexual Cycle*)

It is not necessary to wait for children's questions. With some children you have to break the ice yourself, for they very early learn the taboos about sex, especially if you too are the least bit squeamish.

Always include in sexual instruction not only biological facts but also a reminder of the sociological facts. Give information about what kind of behavior is expected and desired, and why. Don't forget to tell your child that talk about babies is one of the private things in life, to be talked about privately with Mommy, Daddy, doctor, and whomever. Then there will be no bloopers at the dinner table. A child will have confidence in your sociological facts as much as he does in the biological ones you are honest in presenting.

Sexual information is not always well retained. There are many children who need reminders of what they might once have been told.

What are the benefits of proper sexual knowledge?

Proper knowledge of where babies come from is beneficial as an aid to prevention of sibling rivalry. In the most extreme instances of jealousy of the new baby, a two- or three-year-old can mutilate the baby or even kill it, for instance by suffocation under a pillow. The toddler who has been anticipating the new baby for some weeks, and knows that it has already been in the home, in the mother, is less likely to feel ousted by an alien intruder when the mother returns with the little usurper of attention and affection.

Proper knowledge, by the age of five or six, of the preordained role of male and female in reproduction helps ensure continuing normalcy of the male-female psychosexual development, in preparation for the future. Correct knowledge eliminates the need for guessing, conjecturing, and building erroneous theories. It helps ensure that the proper power of erotic arousal in adolescence and adulthood will belong to the proper stimulus object instead of to an abnormal one, as in sexual deviations. Proper knowledge prepares a child for mental health instead of neurotic crippling in the sex life of adulthood.

Proper sexual knowledge includes information about what goes on and how to behave in matters of neighborhood sexual curiosity and play, and about how, when, with whom, and under what social circumstances to talk about sex. This information is of immediate utility

to children in successfully adapting themselves to the customs and conformities of their wider social environment. (See *Sex Education*)

What sort of sexual theories do children construct?

Theories in their true sense of verbal propositions organized into an explanation do not appear until the school years and middle childhood. In the preschool years, one gets the prototype of a theory, a brief proposition that may be put into words in answer to a question, and that may be acted out in play, or may simply be inferred from behavior.

A major principle of childhood sexual theories is that they are conjectured to fill in gaps in knowledge in the inquiring mind, not to compete with information already obtained. If the conjecture comes first, to be corrected later by accurate fact, there may be competition for a while between fact and conjecture. The masturbation imagery and erotic dreams of boys with unusually early puberty, as early as four to six years, provide a clear illustration. None of these boys begins by having imagery or dreams of copulation. Instead, the imagery of their fantasies and dreams reflects the state of their information and experience. For example, one boy at age six reported imagery of ladies without husbands whom he ordered to undress; then he kissed them on the bust, the behind, the feet, between the legs, on the belly button, the face—everywhere. With the passage of time, erotic imagery included playful slapping and biting, and otherwise became more varied. Meanwhile the boy had deliberately been correctly informed of the facts of intercourse in order to prevent fixation on kissing and slapping and to promote development of imagery along normal lines, with success. Another boy, pubertal at eight, began with masturbation imagery adapted from Tarzan films in which two women clawed and wrestled with each other until the victor had the vanquished entirely naked.

The erotic imagery of these two boys reflects what they had picked up about sex from life in general and from television in particular, namely that eroticism involves nakedness, kissing, and something forbidden that may need to be coerced from the partner.

In the preschool years, when male-female psychosexual differentiation is taking place, children may adopt a theoretical position that the change from one sex to another is easy—as easy as the change from child to adult by adding sexual hair and either breasts or deep voice and beard. One boy at six disclosed that he had been praying to God every night to change him into a girl. Another boy of eight, also wanting to

be a girl, had a theory that girls start out as boys and then drop off the penis, though his own infant sister's history demanded the proviso that some girls are born different. A theory of turning into a girl is quite likely linked to a theory of being able to have a baby. This pregnancy envy is the counterpart of penis envy in the little girl who wants to turn into a boy.

Santa Claus and Red Riding Hood are still very much a part of child lore, but not the "stork" any more. There are some children whose response to adults' inquiry about the origin of babies is "from the hospital," or "from God." Privately, the majority of these children know about pregnancy, but have not had the information confirmed and cleared for adult consumption. Most children in our culture today do know about the baby coming from the mommy, and they know it because their parents told them.

Knowledge of delivery is more restricted. The substitute theory most commonly held is that the mother has to go into the hospital for an operation to get the baby cut out. Especially for girls, this is a highly undesirable theory, since it may implant a long-lasting anticipatory fear of childbirth. It is good for a girl to know that she has a vagina, which is her baby tunnel, and this knowledge is a full compensation for any envy she may have of so handy and visible a gadget as a boy's penis. Little girls usually do not spontaneously discover the existence of the vagina as a special part of the external genitalia.

Another theory of birth, common especially among children who know that it is not by surgery, is that delivery is through the navel, which opens up for the occasion. One youngster, logically paying attention to the breasts as female specifics, had them as the locus of birth. The theory of anal birth is quite widespread and may persist uncorrected up to the time of menstruation in girls, or even later especially in boys who lead a very sheltered life. Fantasies of giving anal birth to a baby are not infrequent among anal-receptive male homosexuals, and it is quite likely that the origin of this fantasy was coincident in childhood with other aspects of their feminine identification.

Ignorance of fertilization and the role of the male may be remarkably persistent in children raised without access to information or to other children who have it. To explain pregnancy these children commonly fall back on a parthenogenic (reproduction from an unfertilized egg) theory of getting pregnant from eating certain foods. For such children the role of the father is no more than that of provider. Other

children, seeing the relationship between marriage and reproduction, hit on a theory of conception by way of kissing and embracing.

Kissing and embracing, in some childhood theories, may be extended to encompass assault followed by submission. This transition is an easy one in our culture where dramatic convention, for example, in television romance, requires that the female resist the male's first advances. The idea of assault may be reinforced if a child sees or hears copulation without knowing what it is all about. It is possible that the seeds of the psychosexual aberrations of sadism and masochism are sown in these childhood misconstruings.

Do all psychosexual aberrations originate in childhood?

Scientific understanding of the psychosexual aberrations of adulthood is far from complete. In many instances it is easy to find analogies, parallels, and prototypes of the aberration in childhood's experiences and theories. In some clinical cases there are unequivocal records of the origin and first manifestations of the disorder in childhood. Eonism (transvestism), for example, invariably has a history of onset in childhood, and the condition can be found in children. Fire setting can be found in young children, and so can exhibitionism, voyeurism, fetishism, sadism, masochism, homosexuality, and coprophilia. Appearance of these prototypes of psychosexual aberration in childhood may be only temporary, or they may carry over into puberty and become interdependent with sexual arousal and orgasm.

At the present stage of scientific knowledge the problem of the cause of psychosexual aberration—and conversely of psychosexual normality—is not solved. It would be foolish to attribute causal responsibility to the rearing and parental handling of children, without being able to spell out the details. In the meantime, it still remains a good rule of thumb that the best insurance against psychosexual aberration is for a child to belong to parents who psychosexually are healthy and can provide, especially by the precept of their own example, the optimal conditions for healthy development. (See *Sexual Deviation; Homosexuality*)

What are the characteristics of psychosexual development between early childhood and puberty?

Freud called the childhood years, after six or seven years of age until puberty, the latency period. It is not a very accurate term, for the

period is not one in which the child is in psychosexual hibernation, so to speak, waiting for the spring of puberty to arrive. It is not a period of maintaining the status quo, but of doing a great deal of experimenting and rehearsal of things to come. The chief characteristic of this experimenting and rehearsing is that it is done with other children of like age. Such activity takes the place of the child-parent interaction of the earlier years. The change is a change of focus without a clear-cut dividing line. Child-parent interaction never ceases to affect psychosexual development, but even when it occupied the center of the stage at age four, some kindergarten youngsters were already beginning to align themselves, and meaning it, as boyfriends and girlfriends.

In kindergarten and early grade-school love affairs, it is the girl who lays plans on the boy more often than vice versa. He accedes and accepts the role of boyfriend. His role requires that he pay her more attention than other girls, with perhaps an occasional protested kiss, and above all a willingness to project romantic plans for marriage and a cowboy life on a ranch, or a honeymoon in Paris. Many girls at seven or eight can produce visionary details of their wedding dress and ceremony.

Genitopelvic sexual play is not an integral part of early school-age romance. Between children and in neighborhoods where such play is an established childhood tradition, or is perhaps winked at by elders, one would expect to find it, as one would also among those primitive peoples who overtly accept or encourage sexual and copulatory play between children.

In our own society, childhood sexual play is nowhere openly encouraged or condoned. It is, therefore, one of the requirements of psychosexual development either that such play be inhibited or that it be kept under cover and not discussed with elders.

Learning to adjust to our code of duplicity in sexual matters is one of the important facets of psychosexual development in the childhood years. One of the first encounters with this code is in the use of dirty words. At four there may be a period of name-calling using the baby-talk words for eliminative functions that have a playful appeal simply because they are forbidden words in such a context. Subsequently similar periods may appear, as the child makes his first street and playground acquaintance with vulgarities and swearing forbidden in the home. He tests the limits and learns where they lie. Certain words may be used only with peers, not at home nor in the classroom. Certain kinds of talk are forbidden in front of girls and women, but not among boys and men. Sexual talk should be stylized in a joking, banter-

ing relationship amongst the gang, and only rarely be approached seriously—usually in private conversation with a close friend or with unsqueamish elders, if at all. Sexual jokes and verbal double plays make their appearance at the age of about eight, the age when riddles and conundrums have high appeal.

Early school-age love affairs usually die of their own inanition, for it is another feature of psychosexual development in the childhood years that, after approximately nine years of age, the sexes segregate themselves in play and activity groups. "I hate girls; they're sissy," one hears a boy say with emphatic scorn, and the reply from a girl is, "Boys! They're horrid. They're too rough and they think they're smart." There is some crossing of the barriers. Boys playing football or baseball will let a girl join them, but only if she is a tomboy who knows how to follow a boy's code of honor and who will not resort to feminine wiles and crying. The sissy boy they exclude, and he alone may be acceptable to a group of girls playing "house" or "jump rope."

It is, of course, perfectly in harmony with our cultural mores for boys and girls to segregate themselves, while at the same time the segregation reinforces the mores and transmits them to a new generation. One function of this segregation is that both boys and girls shed any remnants of gender-neutral or gender-identical behavior if custom so requires. Boys assiduously cultivate the mannerisms and manners of masculinity, and girls of femininity, unhampered by the proximity of the contrary example. The model may be an adult, but a much more effective model is the age-group one and two years ahead. In this way, by the end of childhood, an adolescent society appears with its own customs radically different from those known by the parental generation whose own teen-age customs were changed as they were passed on, like a hand-me-down, year by year.

One feature of this stage of sex segregation is a great urge to be grown-up, and there is much rehearsing of grown up behavior. Boys try smoking, or spitting and whistling through their teeth. They want to go hunting or to build camps, forts, and club houses, or to become automobile experts and, above all, drivers. In city slums they become novice racketeers and apprentice gang leaders. Girls start wanting to wear lipstick. They dress up in grown-up clothes and borrow high heels, thereby improving their skill at walking with a feminine swivel. They play at real baby care, housework, and cooking, and they dream of the prince charming who will one day come along. And so on.

What genital sexual play occurs in middle and later childhood?

For all their intolerance of one another, boys and girls in the middle and later childhood years do on occasions make a truce. In any case there are enough occasions of mutual cooperation for sexual experimentation to take place, usually mutual inspection, masturbation, or attempted intercourse. Sometimes only one pair is involved, sometimes a group, and sometimes one girl, more or less willing to curry favor with the boys, is serially favored by all of them.

The exact incidence of prepubertal heterosexual play is impossible to know. It varies with social class, social tolerance, amount of opportunity, closeness of supervision, and so forth. Alfred C. Kinsey said that heterosexual play was found in 40 per cent of the preadolescent histories of males. Among this group, 99 per cent engaged in exhibition, which was the limit for 20 per cent of them; 81 per cent tried mutual manipulation of the genitalia, and 55 per cent tried genital union. Genital union was attempted by 22 per cent of all males interviewed. Among adults, childhood coital play was recalled as three times more common in boys who finished their education without high school than in boys who went to college. The average age of first heterosexual play of any type was between eight and nine years. Two-thirds of the boys carried their heterosexual play on into the adolescent years, whereas others did not persist in it even in childhood.

Among girls, Kinsey found preadolescent sexual play was less common than among boys. Of his female informants, 15 per cent recalled heterosexual play, 15 per cent heterosexual plus homosexual play, and another 18 per cent homosexual play only. In 40 per cent of cases of heterosexual childhood play, only genital inspection was involved; 52 per cent did some touching, but with little genuine masturbation; and 17 per cent tried coitus with actual penetration being probably very rare. The incidence of any kind of sex play was greater between the ages of five and nine than as puberty approached, whereas sex play did not diminish in boys approaching puberty. Very few of the girls had more than one experience of any kind of heterosexual play. Social class differences diverged from those found in boys, for heterosexual play of any kind occurred one-third more often among girls who eventually went to college than among those who quit after grade school.

Many of the same children who experiment with heterosexual play try homosexual play also. Dependent on the thoroughness of the segregation of the sexes, sex play opportunities may be predominantly or

exclusively homosexual. Homosexual play may include fellatio, anal intercourse, and mutual masturbation. Incidence figures again are inexact in the case of homosexual play prepubertally. Kinsey's statistics for homosexual play have roughly the same order of breakdown as those for heterosexual play, except that homosexual play is more common—60 per cent of the boys reported occurrence of some form of it at least once, 48 per cent of adult males recalled it, and 30 per cent of adult females recalled it. Inspection and exhibition is the most common form of homosexual play in juveniles, and two-thirds of the cases try mutual manipulation also. Oral or anal contacts occurred in 16 to 17 per cent of the male cases, and oral contact in 3 per cent of the female cases. In females, objects or fingers were inserted into the vagina in 18 per cent of the cases versus 3 per cent for the same activity in heterosexual play. Preadolescent homosexual play was carried over into adolescence in 42 per cent of the male cases but in only 5 per cent of the female, a ratio in the same order of magnitude as those for petting and coitus. Homosexual play in childhood and adolescence does not necessarily lead to exclusive homosexuality. It may also be the precursor of bisexuality or it may not persist at all.

The genital play of childhood includes solo masturbation, which may be done manually, by squeezing the thighs together, by rubbing or pressing against a suitable soft surface, or with the assistance of various objects. By the age of ten, according to Kinsey's records, some 13 to 14 per cent of children, boys and girls alike, had learned how to masturbate with varying degrees of frequency, some of them allegedly with orgasm, minus ejaculation in the boys.

Masturbation may be done with stimulation from animals. Attempted copulation with animals is also not unheard of prepubertally. It occurs primarily in farm boys and, like most of the more rare aberrances of genital behavior, it is more likely to be encountered at or after the onset of puberty than before.

Childhood sexual play may be between brothers, sisters, or both, and probably occurs with greater frequency than is usually believed, despite the stringency of the incest taboo. Incest may occur between a prepubertal child and an older sibling, parent or other relative, even a grandparent—again with more frequency than is generally recognized. Not all relationships between a prepubertal child and an adolescent or adult are submitted to under force or duress. Occasionally the tables are turned and it is the child who is the instigator. A child may interpret a sexual relationship with a well-liked friend or relative as an extension,

perhaps a guilty extension, of cuddling and affection. Nonetheless, the relationship, since it defies so strong a taboo, has a deleterious effect.

What should be done about childhood sexual play, if discovered?

The first principle to follow in dealing with childhood sexual play, whether voluntary or imposed, is the principle that the chances of normal adult sexual adjustment should not be ruined by the mismanagement of childhood behavior or experiences. Even childhood rape should be handled in this light.

What one tries to do is to get across the idea that what the child did or had done was ill-advised, ill-timed, inappropriate, or socially unsanctioned, but not that sexual relations and sexual pleasure per se are abominable. The offending incident should not be blown up to undue proportions. In general it is the aftermath, even of a traumatic sexual incident, that has more adverse effects than the incident itself. Children have remarkable resilience and can be successfully guided over many obstacles. Heterosexual play is scarcely an obstacle, for apart from being socially unsanctioned, it is rather a promising indication that sexual differentiation is proceeding as desired. Persistence of other forms of sexual play is ultimately undesirable, but to *know* of this persistence is extremely desirable insofar as it alerts one to the child's need for guidance and redirection.

Masturbation is physically and mentally harmless, except when accompanied by worry and guilt. Virtually all children are able to learn that it is a private thing in life that even parents may not like to see. Failure to learn this simple rule is an indication for psychiatric help.

What new phase is added with puberty?

The hormones of puberty change the body shape, the visible appearance and, in the male, the sound of the voice. Without these changes, it is an exceptionally difficult and rarely accomplished feat for a boy or girl to make progress through the psychological and social maturation of adolescence. Much of this maturation is dependent on running with the herd of one's age-mates, egging one another on, learning and assimilating from one another. The comparison of precocious, normal, and delayed puberty makes the power of this group influence abundantly clear.

Puberty is the "haircombing stage," the stage at which boys and girls begin to take notice of one another not as boy friends and girl friends, but as boyfriends and girlfriends. This new, personalized attentiveness

of the sexes to each other is not wholly a matter of hormones, because it can occur in untreated prepubertal castrates. It also can occur in early teen-agers who are awaiting a late puberty. In fact, in the present generation, where the dating age is receding, personalized dating interest may begin as young as eleven or twelve.

The essential something that happens with puberty is that the sexual urge, desire, or hunger is activated. The activating agent is probably the male sex hormone in both males and females—all females have some natural androgen in their hormonal system. Conversely, all males have some estrogen in their bodies, but very little as compared with females. Estrogen seems to be an erotically tranquilizing hormone; its action is different from the other female hormone, progesterone, which more closely resembles androgen. Estrogen takes away sexual urge when men are treated with it for prostatic cancer.

Vague as is the concept of postpubertal sexual urge or hunger, one has no doubt about its authenticity after talking with young boys of seven or eight with precocious physical puberty. There is an immediate common ground between a man and one of these boys in matters erotic that is not present with other children. They know at firsthand the urgency and frequency of sexual drive, its association with certain imagery, and the arousal power of certain perceptual stimuli to set an erotic response in motion.

The relative autonomy of erotic imagery in fantasies, daydreams, and sleep dreams in connection with sexual arousal is a new phenomenon of puberty. So also is the power of certain perceptual stimuli to trigger erotic arousal. And so also, after puberty is well on its way, is the capacity to experience the phenomenon of falling in love. All three of these phenomena can put in their appearance in the teen-age years despite the absence of hormonal puberty, as they do in a few, though not all, cases of untreated prepubertal castration or testicular agenesis (incomplete and faulty development). In such cases the phenomena are rather more attenuated than they subsequently become when charged up with androgen.

What is "falling in love"?

The obvious answer to this question is that it is what the poets and novelists have been celebrating for centuries. Science can go only a little further.

To whatever extent it may be conditional on sex-hormonal functioning, "falling in love" seems also to be conditional on maturation within

the nervous system of a capacity to respond erotically to a certain type of perceptual stimulus, especially a visual one. Further, this response has the additional characteristic that it fairly readily may become imprinted onto one particular stimulus that thus becomes the love object. There may be love at first sight, or only after long acquaintance. The love object then exercises extraordinary priority and preeminence in being able to elicit erotic response from the partner. This state of affairs may for a while be mutually exclusive of all other love objects and erotic responses for each of the partners. As time goes on there may be interference from outside competition, weakening but not breaking the bond between the pair, which may endure for a lifetime. Or, the bond may weaken and lose at least one of its attachments, so ending not a lifetime (as in geese and jackdaws), but only an episode of monogamy. In many ways man is, erotically speaking, an episodically monogamous animal.

What are the perceptual precursors of falling in love?

The sign-stimulus to which a falling-in-love response becomes imprinted is, in normal psychosexual development, a member of the opposite sex. Long before falling in love takes place, the young adolescent has had plenty of intimations, in his dreams, fantasies, and perceptions, of what kind of stimuli have preferential power to arouse him. Early puberty, especially for boys, is the beginning period of pinup magazines, bawdy stories, and, when available, pornographic publications. Though so heartily frowned upon in our society and withheld from young teen-agers, these materials actually have much to commend them. They demonstrate normalcy of psychosexual response and promote continued normalcy. The real problem of pornography, so-called, for the adolescent is not to pretend that he has no response to it because it does not exist, but to become skilled and morally responsible in allocating these responses to their proper place and time in his life.

For all that is known of the psychology of pornography, perceptual erotic stimulation in early adolescence, properly used, might conceivably have an important role in directing an adolescent's erotic susceptibilities and in loosening up exaggerated inhibitions to permit accurate rehearsals of psychosexual maturity.

For the most part, however, it is likely that the psychological rudiments of the kind of perceptual imagery that will have primary erotic arousal power are laid down well before puberty. At puberty the arousing images reveal themselves in full and their power is subsequently per-

sistent and resistant to substitutes. Such seems to be so in the case of complete psychosexual normalcy or of severe aberration. Individual idiosyncrasy and specificity of erotic imagery is quite remarkable. Inhibition and repression may delay a person's full recognition of the erotic perceptual imagery that has primary arousal power for him, but it is very unusual to find major and permanent changes in adulthood, e.g., substituting homosexual for heterosexual imagery, in the absolute absence of antecedents.

Are there male-female differences in perceptual and cognitional threshold?

Phylogenetic differences between the sexes in matters of erotic arousal are exceptionally difficult to disentangle from culturally prescribed ones that have become embedded in the personality. Individual differences are so greatly diverse that it has not yet been possible to get an answer to this particular question from the study of hermaphroditic individuals of the same diagnosis distributed by assignment to the two sexes. There is, however, some suggestion that the male and female hormones may play a part in sex differences of arousability observed in morphologically normal males and females.

The sex hormones definitely bear no relation to the content of imagery that has arousal power. For example, the sex hormones do not cause homosexuality or control the content of the erotic imagery of homosexuals.

Whether the explanation lies in androgen level or in cultural training, men more often than women are sexually restless and alert to the sexual stimulus value of strangers of the opposite sex. Women more often than men find themselves aroused only by someone with whom a romantic and sentimental relationship already exists. Perhaps one may hazard the guess that there is a phylogenetic vestige of preparing a lair and raising the cubs, possibly related to estrogen function, in this more quiescent, stabilized eroticism of some women.

It is conjecturally possible that, as a counterpart of feminine, estrogen-mediated reliance on the status quo, there is an androgen-mediated phylogenetic vestige in males of the mechanism seen more highly developed in some others of the mammalian species, for the claim and defense of territory and breeding-ground rights. This conjecture helps take account of the greater geographical roaming of pubertal and adolescent males than females, their greater involvement in exploits of daring, adventure, and belligerence, their greater involve-

ment in delinquency thereby, and their greater readiness to get into fights over their mates.

Kinsey presented the thesis that women, to be aroused erotically, are more dependent on touch than men are, men being more easily aroused by erotic sights and sounds than are women—an assertion certainly borne out in the box offices of burlesque theaters. This sex difference in perceptual arousal parallels the Kinsey finding on sleeping orgasm with accompanying dream imagery. Only 37 per cent of the women in the sample reported orgasm dreams, by contrast with 83 per cent of the men. Further, in women, dreams culminating in orgasm occurred with greatest frequency between the ages of thirty and fifty, but during the immediate postpubertal teens and twenties in men. These differences between men and women are not absolute, and the amount of overlap is probably quite extensive.

According to the evidence currently available, and that chiefly from hermaphroditic studies, there are no genetic, chromosomal determinants directly responsible for sex differences in erotic responsiveness or imagery.

What are the sex education needs of puberty?

Ideally a child will reach puberty correctly knowing at least the basic essentials of human reproduction and of what to expect of his or her own body and mind in erotic functioning. The special need of puberty and adolescence is for sociological information and guidance regarding the behavior of the sexes together. Knowledge of how one thing leads to another in the progress of love play from petting to coitus is necessary, especially for a girl who wants to keep from getting pregnant, if she is to avoid being caught with her emotional guard down.

Teen-agers do, of course, teach one another a great deal about boy-girl behavior, through example and talk, but it is a burden on them to be deprived of adult wisdom in talk and books. Preferably there should be equal ease between a teen-ager and both parents. Parents may not be enough. A teen-ager may need discussions with an impartial outsider from time to time, since so many of the issues of adolescence involve the very issue of independency. Moreover, some parents are too handicapped by their own prudery, especially when teen-agers have problems of psychosexual aberration.

One of the chief psychosexual assignments of the teen-ager is to break

from juvenile dependent attachment to the parents and to become dependent on a mutual love attachment in order to become a parent himself, attached to dependent children. As every parent of teen-agers knows, there are many household struggles around the issue of adolescent autonomy versus compliance.

What a teen-ager does not know from the vantage point of his own group experience is that the mores and customs of adolescent relationships are varied the world over and, in recent times at least, from one generation to the next. In the last three or four generations our society has seen radical changes in the dating and marriage ages, in chaperonage, in "playing the field" versus going steady, in necking, petting, and having intercourse before marriage, and in using contraceptives.

Disapproval of, or failure to recognize, a change between one generation and the next is a source of much strife between parents and teen-agers.

What are the present teen-age mores?

The present generation of American teen-agers begins dating earlier than the last, as young as twelve or thirteen in some localities, and has adopted the system of "going steady," with its attendant rituals of exchanging pins or rings as tokens. They do not know why they have introduced these changes. A complexity of sociocultural factors is doubtless responsible, including economic emancipation of adolescents in an affluent society, parallel with prolonged schooling and unemployability; the vague, hydrogen bomb threat that life may be all over before it has begun; and the sexual emancipation of girls from Victorian prudery, together with the availability of almost perfectly safe and inexpensive contraceptives.

Safe, inexpensive, and easily available contraception is new to the human race in the past half century, and we have not yet made up our minds on the rules and conventions for when it may be used. Certainly contraception has not been hailed as the perfect answer to teen-age sexual play. Teen-agers use contraceptives, but almost in spite of themselves. Their code says: "No intercourse," and the girl is supposed to resist, the boy to persist. Petting to climax is permitted, but virginity, or the pretense of virginity, must be retained until marriage.

In some teen-age circles the rule of virginity is obeyed. In others, boys and girls both keep up the fiction of virginity, if they have had premarital intercourse, by not having it with the one they will marry.

A new amendment gaining acceptance as part of the teen-age code permits intercourse before marriage but only with the one you are engaged to marry.

Variations in the teen-age code are dependent partly on locality, socioeconomic status, and other determinants of group segregation and identity. But these variations are also dependent on individual personality differences. In a single locality or school, teen-agers subdivide into groups with different sexual morality. For example, there are the rock 'n' roll set and the hot rodders, some of whom are prone to delinquency and sexual promiscuity, versus the squares and the creeps, some of whom are academically serious and ambitious and more reserved in their dating and going steady. Usually there is no special name for the in-betweens, and sometimes no in-between group. It is a tough dilemma that some teen-agers are thrown into, to have to make a decision about group loyalty and identity. (See *Juvenile Delinquency; Adolescence; Courtship and Engagement*)

What psychosexual development follows adolescence?

The distinguishing mark of young adult psychosexual development is parenthood and all the behavioral changes and adaptations attendant on maternity, fatherhood, and child rearing.

Among adults, the frequency of sexual response is extraordinarily varied, ranging from only a few times a year to several times every day. Some people never have an orgasm, notably frigid women, whereas it is well verified that others, men as well as women, can have upwards of twenty complete orgasms in twenty-four hours. These vast differences of orgasmic capacity are not a function of hormonal levels, but of the functioning of the central nervous system as applied to sex.

According to Kinsey, the peak of orgasmic potency in males is in the late teen years and the twenties, whereas in women it is in the thirties and later.

The frequency of adult sexual urge and activity may be temporarily diminished or abolished by debilitating disease, starvation, or hormonal deficiency. Loss of urge and activity from castration can be restored by hormonal therapy. Depression of urge and activity may also occur in the wake of life history experiences that have an inhibiting influence on sex, as in some instances of impotence and frigidity. (See *Sexual Relations and Marriage; Marital Problems and Marital Adjustment; Conception, Pregnancy, and Childbirth; Impotence; Frigidity; Sterility*)

What are the psychosexual features of middle life?

The next psychosexual landmark of adulthood is the completion of child care in middle or late life when the youngest child leaves home, independent. Adjustment to this change is for some parents as great a challenge as parenthood was. Mothers especially, their major vocation in life completed, are left high and dry, if the relationship with the husband is already terminated or emotionally sterile. Grandchildren may fill the void, or there may be other activities to substitute for caring for offspring.

Completion of child rearing usually follows the menopause, a hormonal upheaval that may interfere with psychosexual function either directly or derivatively. Some women report, and perhaps expect, a dying of sexual urge after the menopause. Some experience its resurgence. Some mourn the loss of childbearing, others celebrate it.

Despite occasional claims to the contrary, there is no hormonal counterpart of the menopause in males. (See *Menopause; Adulthood; The Adult Male*)

What are the psychosexual accompaniments of old age?

Advanced old age, in both sexes, is accompanied by a gradual quiescence of sexual urge with diminution of potency and of the frequency of sexual activity and orgasm, which need not, however, be totally lost.

Geriatric loss of potency in men may be corrected in many instances by androgen substitution therapy. The effect of hormonal treatment on geriatric loss of sexual urge in women is debatable. Some gynecologists have reported obtaining results from treatment with androgen in sufficiently small amounts not to produce virilization (development of male secondary sex characteristics). Estrogen is necessary to abolish vaginal dryness and tenderness, unless an artificial lubricant is used.

In some few old people, the cerebral deterioration of senility impairs the normal psychosexual tranquility and restraints of old age and reactivates earlier, even juvenile patterns, of erotic behavior. The principle seems to be the same as in the deterioration that destroys bowel and bladder control. The consequences may be embarrassing and, when improperly interpreted, tragic, as death can be tragic. (See *The Aging and the Aged; The Senile Psychoses; Hormones and Behavior*)

PSYCHOSOMATIC ILLNESS

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What is meant by psychosomatic illness?

Unfortunately, this term is a misnomer that has become such an integral part of our general vocabulary that it is too late to replace it with a more appropriate one. It is misleading because it implies that certain physical illnesses (including the structural changes of disease) may occur as simple and direct consequences of psychological difficulties. The idea that any single specific factor may be regarded as responsible for occurrence of a disease state does not fit with the most current concepts in medicine. For example, we no longer regard the tubercle bacillus as the "cause" of tuberculosis, but think rather that the development of active clinical tuberculosis results from complex interaction of many factors, including exposure to tubercle bacilli, virulence of these bacilli, the age, sex, race, nutritional status, and psychological adjustment of the patient at the time of exposure, etc. In other words, modern concepts of etiology implicate multiple rather than single factors, and the interplay among them may be quite complex and even circular. In the initial stages of bodily invasion by the organisms of tuberculosis, easy fatigability and general loss of energy may develop as early symptoms. Psychological reaction to these might then lead to changes in behavior that can indirectly influence the outcome of the struggle between the invasive powers of the bacilli and the resistance of the patient. Some people respond to such a symptom by denial, and they may even overcompensate to prove it. At the very time when more rest and careful attention to nutrition and general hygiene would reinforce the body's defenses, this psychological reaction might lead to just the opposite—namely overactivity and general carelessness about diet and hygiene. It is not hard, either, to imagine how a psychological reaction of this type, persisting stubbornly into the stage of active lung damage, could interfere with the patient's willingness to cooperate with his doctors and to benefit fully from the treatment measures made available to him.

This example embodies a second basis for dissatisfaction with the term "psychosomatic illness." The term alludes only to half the story, since it refers only to chains of events that begin with psychological conflicts and end (albeit by complicated mechanisms) in disease process. As more and more clinical research has been directed at the interplay of mind and body in health and disease, the more we have come to appreciate the clinical importance of sequences that go in the opposite direction; namely, the psychological consequences of being ill (somatopsychic sequences).

Since the word "psychosomatic" has become so firmly established in common usage that it is not feasible to discard it, we prefer to speak of a "psychosomatic approach" and "psychosomatic mechanisms" rather than of psychosomatic illness or psychosomatic medicine.

How do you define the psychosomatic approach? Does it constitute a new specialty in medicine?

The psychosomatic approach can best be defined by elucidation of the four features that characterize it:

"1) The sick *patient*, rather than the *disease* process itself, always occupies the central position in the focus of the doctor's attention.

2) It is an approach which recognizes the interaction of physiological and psychological forces in two directions. First, it allows for a consideration of the etiological or contributory role of emotional tension as one of a system of multiple factors in the genesis or precipitation of physical illness, and second, it recognizes the role of physical illness as a profound life experience capable of producing psychological sequelae which may be intimately bound up in the total clinical problem presented by the patient.

3) It is an approach which attempts to apply the best and most modern psychodynamic understanding of human personality function in all phases of medical practice—diagnosis, therapy, and research.

4) It is an approach which recognizes the doctor-patient relationship to be a two-way interpersonal reaction system and pays attention to the psychological participation of both patient and doctor as pertinent factors in understanding and influencing the patient's clinical course.

It should be clear from this characterization that the "psychosomatic approach" in this sense is in no way conceived of as a substitute for standard accepted medical procedure, but rather that

it attempts to broaden the scope of the physician's approach through the application, in perspective, of an additional body of information (namely the psychology of human behavior) to his efforts at dealing with medical problems."*

Further, it is clear that it does not constitute a new specialty or specific discipline dealing with a selected group of diseases or patients, but rather that it constitutes a point of view appropriate in varying degrees to all medical patients.

Are there some diseases in which psychosomatic mechanisms play a particularly important etiologic role?

The answer to this question is, "Yes," but it is extremely important to understand that their role is contributory and probably varies in importance from case to case. The diseases in this category are: essential hypertension, peptic ulcer, bronchial asthma, thyrotoxicosis (hyperthyroidism), rheumatoid arthritis, ulcerative colitis, and neurodermatitis. It seems clear that emotional factors may exert considerable influence on the clinical course of these diseases, and it is also thought that they may in combination with other factors contribute to the development of these conditions. The relative importance of psychological to other factors (such as constitutional factors) is not fully understood and seems to vary considerably. For example, in some patients with bronchial asthma, allergic factors seem to play a small role relative to psychological factors, and in other instances just the reverse seems to be true. In many, both allergic and psychological mechanisms seem to be important. It is not known whether psychological conflict alone could produce any of these diseases, but most authorities in the field doubt it. On the other hand, many, but not all, authorities are inclined to think that these diseases would not develop without it (psychological tension) being present to some degree. In more technical terms, psychological conflict might be regarded as a "necessary but not sufficient condition" for the occurrence of these particular illnesses.

What are psychosomatic mechanisms? How can emotions lead to physical changes in the body?

It is, of course, well known that strong emotions are accompanied by changes in body function, such as rapid heartbeat, perspiration,

* Quoted from "Principles of Management of Psychosomatic Disorders" by Milton Rosenbaum, M.D. and Morton F. Reiser, M.D., in *The Medical Clinics of North America*, W. B. Saunders Company, Philadelphia, London, May, 1958.

breathlessness, and trembling in association with fright. Symptoms of sustained nervous tension, e.g., diarrhea, frequency of urination, headache, nausea, indigestion, etc., experienced before important examinations, interviews, etc., are part of everyone's experience. Extensive and meticulous studies have been carried out both in animals and in man, and it has been possible to measure and describe functional changes in most major systems of the body under conditions of acute and chronic stress. These changes constitute normal physiological adaptation to stress and can be regarded as mechanisms that prepare the organism to cope with danger. For example, Walter B. Cannon regarded the immediate physiologic alterations occurring in frightened animals as preparation for the muscular exertion of "fight or flight." These alterations in function lead to acceleration and redistribution of the circulating blood so that a greater proportion goes where it is needed, that is, to the skeletal muscles and vital organs (heart, lungs, and brain) while less goes to the skin and the digestive organs that are not called upon for much work under these conditions. One leading theorist in the clinical field, Franz Alexander, has postulated that chronically sustained emotions may be accompanied by chronically sustained concomitant physiologic changes, i.e., that a continuing state of anger may be accompanied by a continuing elevation of blood pressure. Functionally, an acute rise in blood pressure may be caused by spasm and consequent narrowing of thousands of tiny arterial vessels (arterioles) throughout the body. Ordinarily, these vessels relax and the blood pressure returns to normal when the acute emotional state has passed. If for psychological reasons the emotion cannot be adequately expressed in speech or action, Alexander theorizes that the physiologic constriction of the arterioles will persist and that the sustained contraction (and elevated pressure) may then lead to permanent changes (narrowing and stiffening of these vessels), which from then on would provide structural basis for the hypertension. Similarly he feels that chronically maintained excessive acid production by the stomach in association with unresolved emotions may contribute to formation of an ulcer in the lining of the stomach (peptic ulcer). These statements represent only a part of Alexander's theories which, in their entirety, encompass a great deal more. They are mentioned here as representative of the concept (shared by many investigators) that changes in body function, ordinarily normal adaptive accompaniments of emotion, may, if exaggerated and sustained, become maladaptive. If exaggerated or unduly prolonged, they might then contribute to the

development of irreversible structural changes in body tissue. On the basis of what we know, this is how it could happen. The exact way in which it does happen is still unknown.

What determines which disease a person will get? Do certain specific emotional problems lead to specific diseases or can strong unresolved psychological conflict lead to any one of these diseases?

There has been and continues to be a great deal of controversy about this issue, and eminent authorities take opposite positions about this question. (When this is the case, it usually means that the answer is not yet known.) On the one hand, there are some who consider that the changes in body function which accompany emotional arousal, such as those described above, are nonspecific and that physical disease developing under the impact of sustained emotional tension will occur in whatever organs are most vulnerable because of hereditary or constitutional factors. In other words, when the organism is put under stress, trouble will develop at the "weak link in the chain." On the other hand, many clinicians and investigators feel that there are important differences in the psychological sphere between patients with different "psychosomatic diseases" and postulate that each different emotion is accompanied by its own specific pattern of physiologic arousal and so consider that the type of emotional conflict plays a role in determining which tissues will be damaged and hence which disease will develop. In the examples cited above, it is implied that conflicts having to do with the expression and discharge of anger would be more likely to activate a disease of the cardiovascular system such as hypertension, whereas conflicts around receiving love and being cared for, would be more likely to interfere with stomach function and lead to a disease such as a peptic ulcer. Although a great deal of research has been directed at this issue, the findings are not clear-cut and advocates of each point of view can find partial support in the results. Most physicians interested in this field, but not actively partisan in the controversy, consider that the question is still open, and tend to feel that the truth may lie somewhere in between. Compromise theories that consider both constitutional-genetic and psychological factors as determinants in choice of disease have been advanced by many investigators, including Franz Alexander, I. Arthur Mirsky, Roy R. Grinker, Felix Deutsch, and others. The important point to emphasize here is that it is clear that emotional factors may contribute to the development of

certain diseases and influence their course even though full explication of the mechanisms involved has not yet been achieved.

Some people have persistent and recurrent physical symptoms such as headaches for which the doctor can find no physical basis. Are such symptoms "imaginary" because they are "all in the mind"?

No pain or bodily discomfort is ever "imaginary." A large proportion of such symptoms actually originate in functional rather than structural bodily changes. For example, a large proportion of headaches arise as the result of tension (mild sustained contraction) of the muscles of the neck and scalp that lead to soreness and pain originating in these muscles. This pain is just as real as that arising from a tumor which can be seen or palpated (examined by the hand), or otherwise detected by special laboratory examination such as the X ray. Similarly, diarrhea and abdominal cramps that originate in disturbed circulation and muscle tone of the intestines do not feel different from diarrhea resulting from infection of the bowel. In some cases there is no demonstrable functional disturbance in the body tissues. In these instances the sensation of pain and discomfort arises as a result of purely psychological mechanisms such as *conversion hysteria*. The symptom and discomfort is nonetheless real to the patient. It should be remembered that psychological processes underlying such symptoms are outside the patient's conscious purview and voluntary control. In other words, the symptom is in fact imposed upon the patient by forces beyond his control and is experienced in the same way as when part of the body is injured, diseased, or functioning improperly.

Is the diagnosis of a psychosomatic or functional symptom made mainly by a process of elimination? Is it proper to label a symptom in this way when careful medical and laboratory examination has failed to reveal the presence of organic disease process?

No. Ruling out the presence of organic disease constitutes only half of the diagnostic procedure. The physician should also attempt to make a positive diagnosis, that is, he should attempt to determine if indeed there are relevant emotional problems, and if so, to identify them insofar as possible. If in such an instance careful and competent search for a psychological explanation of symptoms fails to uncover probable causative psychological factors, the question of the com-

pleteness of the medical work-up may be legitimately reopened. In instances of this sort, it sometimes develops that an error of omission has been committed in the course of the medical study.

How can psychological reaction to an illness become a problem?

It is natural to be upset by illness, and as long as the psychological reaction represents only a simple and direct response to the realities of the situation it presents no special problem. Reactions of this nature, which represent the majority, respond to commonsense understanding and competent reassurance. Physicians have to be alert though for the circumstance where anxieties attendant to illness persist unduly, or succeed in reviving older and latent neurotic conflicts that were not clinically manifest before the patient had to cope with the problem of physical illness. When latent neurotic problems are activated, or current ones exaggerated, the problem of total management may be complicated in one or more of several ways.

First, if the anxiety becomes excessive, it may in certain conditions throw additional strain on diseased organs and in this way aggravate the illness. For example, extra anxiety represents an extra burden on the already overburdened heart of the patient with congestive heart failure. When neurotic anxiety is mobilized, a cardiac patient may react to a mild physical symptom such as slight difficulty in breathing (which in reality reflects only a mild and transient degree of cardiac insufficiency) as if he were in danger of immediate suffocation from a major "heart attack." The additional work load imposed upon his heart by the anxiety may then lead to a more serious degree of failure, which in turn aggravates his symptoms and further increases the apprehension, etc. A cyclic reaction of this kind is not difficult to manage once it is recognized, e.g., through judicious use of extra sedation. If unrecognized, the patient's worsening condition may lead to the erroneous impression that the degree of heart damage is more severe than is actually the case.

Second, activation of neurotic conflicts may lead to emotional reactions with behavior that is maladaptive in the sense that it interferes with medical management. For example, the patient who will not "give in" and admit that he is really ill may refuse to take medication, or to follow a diet, or to remain in bed when this is necessary. In milder forms a reaction of this kind can be manifest by "forgetting" to take important medication or "not understanding" the doctor's instruc-

tions, and undertaking proscribed activities, etc. In other instances, the reactions may be in the opposite direction and result in prolonged convalescence and psychologically determined chronic invalidism.

Finally, the maladaptive responses may be in the psychological sphere, e.g., depression. Medical illness may precipitate a mental disorder requiring attention in its own right.

When a patient's problem initially seems to be purely medical, how can the occurrence of important emotional problems be detected and evaluated?

Ideally and properly, detection and initial evaluation of these problems belongs with the nonpsychiatric physician—most commonly the general practitioner, internist, or pediatrician in the case of children. Initial assessment and evaluation of the patient's mental health is a natural part of a complete medical appraisal. The physician's training and skill in these matters will determine how far he can go in pursuing evaluation and treatment. In the majority of cases, his preparation in medical school and his experience qualify him to deal with these problems. If there is difficulty or confusion about this issue, to a large extent it may be because some physicians and laymen tend to neglect or overlook personal and psychological matters in their approach to disease. To the extent that this is a problem, it is one that can be corrected by both professional and public education. Frequently, and in many instances, psychological factors cause difficulty, not because they are so complicated, but because they are overlooked and neglected and then tend to become chronic and exaggerated. In a surprisingly large proportion of cases, general physicians and patients together can discover important areas of psychological tension, and the physician can deal with them effectively once they are recognized. When the doctor finds that he is encountering a problem more complicated than he feels qualified to handle, this is the time to refer the patient for consultation to a psychiatrist for further diagnostic evaluation. Incidentally, patients do not ordinarily resent referral to a psychiatrist under these conditions, that is, after they have already learned through working with their own physician that these matters are relevant and important. Some patients may, on the other hand, tend to be resentful of referral to a psychiatrist if psychological matters have been ignored by the physician and are then only mentioned in connection with recommendation to consult a psychiatrist.

In cases where emotional problems are of major proportions, how should the treatment be managed, and by whom?

Medical management often requires teamwork between the psychiatrist and the referring physician. The exact roles of the two physicians will vary depending upon the degree of competence possessed by the medical physician for dealing with psychological problems, and also depending upon the nature of the medical problem. In some instances, the patient may remain entirely under the care of his medical physician, with the psychiatrist merely consulting from time to time in order to help the internist in evaluating the problem and formulating treatment procedures. In other instances, the problem may be managed simultaneously by the psychiatrist and general physician, with the two of them conferring as necessary. In still other instances where the medical problem is relatively quiescent, the patient may be referred for management primarily by the psychiatrist, with regular checkups by the internist and consultative medical treatment whenever this becomes necessary.

If the general physician and internist are the ones who should deal with the majority of these problems, are there enough of them adequately trained to be competent and comfortable with this job?

This question has to be answered in several parts. As mentioned above, all physicians, by virtue of their training and experience, are qualified to conduct an initial inquiry into these problems. How far they can go with them will vary, of course, from individual to individual. Considering the general prevalence of nervous tension in our current society, it is hoped that more and more physicians will be equipped to do more extensive work in this area. In this regard, there is reason to be both pleased and optimistic. During the past ten years, there has been a tremendous and impressive increase in both the quantity and quality of instruction about human psychology and the role of psychological factors in illness in the medical curriculum. The result of this is that recent graduates have had a chance to catch up with their older colleagues whose competence in these matters has been acquired less by formal education and more by experience. This trend to give more emphasis to these problems in medical education is continuing—existing courses are being strengthened and more and more medical schools are providing additional time for this subject.

Does psychotherapeutic discussion have an effect on a medical disorder such as hypertension?

The answer to this question can best be understood if we first state directly the rationale and goal for psychotherapy under these circumstances. Stated simply, what we try to do is to prevent emotional tensions from activating the physiologic pathways in the body that are involved in the disease process. Thus, if unresolved emotions arising in marital conflicts are keeping the nerves responsible for constriction of the arterioles in a constant state of increased activity, it would be our goal to somehow "disconnect" the emotional conflicts from the arterioles and the nerves that affect them in order to allow more relaxation of the small blood vessels and reduction in blood pressure level and in the pace of the disease. Of course, in most instances, we cannot fully achieve such an ideal goal, but there are a number of ways in which we can approach it quite effectively. All of them function through the relationship that develops between the patient and his physician. To begin with, a surprisingly large amount of tension often dissipates as the patient begins to experience the physician as someone competent, reliable, dependable, and nonjudgmental with whom he can share his troublesome worries and intimate conflicts. This is even more true when the patient realizes that the physician can also be depended upon to think actively with him about ways of resolving personal difficulties, as in a marriage. Often the physician as an objective observer is able to make constructive suggestions to the patient and/or the family, which lead to improvement in relationships and consequent reduction of the amount of unresolved emotional tension.

Tension reduction may also be achieved through emotional reeducation; for example, difficult feelings may be accumulating within a patient because of unrealistic neurotic guilt and embarrassment. He may feel guilty and ashamed because he regards some of his feelings (such as anger) toward his wife and children as exaggerated and abnormal. When he is able to bring these feelings and his discomfort about them to light in discussion with the physician, he may learn to be more tolerant of them and even to express them more freely when it is appropriate. This is achieved not only through the verbal messages contained in the doctor's statements, but also through corrective emotional experience, i.e., experiencing absence of the disapproval he had expected to encounter in the doctor's response. Insofar as intellectual and emotional learning allows for freer acceptance and ap-

propriate expression of previously bound emotions, the amount of tension that accumulates inwardly (and finds expression in physical pathways in the body) will be diminished.

There is another important way in which psychotherapeutic discussions may be helpful. This is through the identification of those special relationships and specific life problems that tend to keep the patient stirred up. A patient, although he did not realize it at the beginning, may learn that certain specific situations in his life almost always lead to trouble when he encounters them. For example, it may become clear that the symptoms of his illness and the level of his blood pressure have usually been worse when he has been involved in contract negotiations between his union and his employers. When this is the case, the old adage applies: "To be forewarned is to be forearmed." When this situation is next encountered, doctor and patient both realize that it will be stressful. They can plan constructively for it, through scheduling additional appointments, providing for extra participation in relaxing recreation and hobbies, increasing medication, etc. In some instances, serious episodes of illness may be prevented by a brief period of hospitalization for intensive treatment and rest.

All these mechanisms can operate within the framework of combined medical and psychological treatment without recourse to highly specialized techniques that are utilized in formal intensive psychotherapy and psychoanalysis. These latter techniques have as their goal reorganization and reintegration of personality structure, so that interpersonal relationships can be negotiated with minimal residual unresolved conflict.

How much can actually be accomplished by the combined medical-psychotherapeutic approach?

This, of course, depends upon many factors, most important of which are the severity of the medical condition and the severity of the psychological disturbance. In most instances, the combined medical-psychological approach as described above can reasonably be expected to lead to considerable improvement in symptoms, at the very least. In many other cases, it seems that the rate at which a disease proceeds can be slowed, and in some instances severe complications averted. We do not yet know whether intensive psychotherapy can be successful in "curing" or permanently eliminating these diseases.

Does having a disease such as hypertension, peptic ulcer, bronchial asthma, thyrotoxicosis, rheumatoid arthritis, ulcerative colitis, or neurodermatitis constitute in itself an indication for intensive psychiatric treatment such as psychoanalysis?

No. Appraisal of the indications and contraindications for intensive psychotherapy and psychoanalysis have been worked out primarily in (individual) psychological dimensions. Since we certainly cannot generalize about the role of psychological conflict in the causation of these diseases, it does not seem proper to recommend major psychotherapy for any specific individual simply because he happens to have one of them. On the other hand, patients with such a disease, particularly those in whom the disease is still reversible, may properly be referred for thorough psychological evaluation with the question of intensive psychotherapy in mind. If it is found that the patient in fact has major problems in the psychological sphere, and if these psychological problems warrant (and are amenable to) psychoanalytic therapy, then such therapy can be undertaken in its own right. Under these circumstances, the patient and the physician can both carry some reasonable hopes in regard to the medical problem. In the course of the patient's psychoanalysis, it may turn out that his unresolved conflicts are indeed intimately involved, and exerting a major influence upon the medical condition. If so, successful analysis of these problems can be expected to lead to considerable improvement in the medical sphere. Indeed, this sometimes turns out to be the case. When it does, it is best regarded as a fortunate extra dividend rather than an expected return on the capital investment.

PSYCHOSURGERY

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What is psychosurgery?

It is brain surgery carried out for the relief of mental symptoms. These operations are confined almost entirely to the frontal lobes.

What is its history?

Trephining of the skull has been practiced since paleolithic times. It is thought that at least some of this was done to "let out the demons" which, until three or four hundred years ago, were generally believed to be a cause of mental symptoms. The modern operation dates from an observation on two chimpanzees which showed decreased reactions of frustration after frontal lobe operations. Antonio Egas Moniz (1936) then reported a series of twenty cases of schizophrenia on which surgery was performed, two-thirds of them with favorable results. This surgical procedure was taken up in the same year by Walter Freeman and James W. Watts, who devised an improved operation. All this occurred at a time when other somatic treatments—insulin, Metrazol, and electric shock—were being rapidly developed. The acceptance of these methods opened the way for considerable application of various types of psychosurgery in the latter part of the 1930's and throughout the 1940's. In Great Britain alone, over ten thousand patients have had this operation, mostly before the introduction of the tranquilizing drugs in the early 1950's, which everywhere was followed by a sharp reduction in the amount of psychosurgery.

What are community attitudes toward psychosurgery?

Psychosurgery today is often regarded with much disfavor in the United States as well as in many foreign countries, both by the lay public and the medical field. Soviet Russia has long since outlawed the operation, yet in Great Britain, where mental hospital policies are among the most liberal in the world, the operations are still being carried out, although in very reduced volume. The reasons for our

attitudes are complex and perhaps not entirely logical. All intervention in mental and emotional illness has had to face strong objections, beginning with the sixteenth-century movement to classify the mentally ill as "sick" rather than as "possessed by demons." There was bitter objection to the intervention by Franz Mesmer and his disciples in the late eighteenth and nineteenth centuries. Sigmund Freud and his approach were violently condemned, as were the various forms of shock therapy and the use of the tranquilizing drugs. In addition to the fundamental resistances, the brain operations had to face the objections that they were empirical in nature, produced irreversible changes and, in some cases, left undesirable personality effects.

What are the attitudes of the family when a member undergoes psychosurgery?

Speaking from an experience of approximately one thousand cases of psychosurgery, the author would say that the attitude of the family is highly variable. A common denominator is the conviction that after full consideration of the risks and the problems associated with the operation, and of the alternatives that must be faced—intractable mental symptoms and their consequences—the operation is the necessary choice. It is helpful to have the family accurately advised in advance, and if the proper selection of cases is made, the attitude of the family is usually positive. The real problem is the partially recovered patient in whom the operation has led to improvement, but not enough improvement to permit fully independent living. In all cases the acceptance and patience of the family is an important factor in the final outcome.

What is the attitude of the patient toward his operation? How can his attitude affect his recovery?

Immediately after the operation, patients regularly deny the fact that they have had an operation, and this experience plays a surprisingly small role in their thinking. In any event, there is much less tendency to attribute the various postoperative symptoms to the procedure than, for example, in electroshock therapy. The patient's attitude toward his illness and his treatment does influence progress, but the reverse is also true: when the patient is improving, his attitude toward his treatment tends to improve, and it is hard to distinguish cause from effect.

On a theoretical level, it is difficult to rule out placebo effects, that is, effects due entirely to the attitude of the patient toward the operation, inasmuch as it has not been possible to provide scientific "con-

trols" (such as are used in drug therapy). From the practical point of view, however, the writer feels that it has been well established that persons suffering from severe major psychoses and intractable behavior disorders are not placebo reactors. This is being established in a rather convincing way in connection with recent work on psychiatric drugs, generally, and the tranquilizers, in particular.

What is the medical profession's attitude toward psychosurgery?

The medical profession is and has been divided on this question, and it is probably fair to say that a majority, in the United States at least, now sees little or no place for the operation. However, those who have had experience with the technique feel that it has been prematurely abandoned and that it still can help many who can get relief in no other way now known.

What are the major psychiatric problems with which psychosurgery deals? How successful is it?

Why and how psychosurgery works is not known, but one can say the same thing about insulin, electric shock, and many other established methods of treatment. Undoubtedly, the largest field for surgery in the past has been intractable schizophrenia, especially in cases with severe behavior disorders. Depressions and manic states have also responded to surgery. Certain neuroses and allied states with extremely disabling and unpleasant symptoms have responded well to smaller operations. Where the mental illness is secondary to demonstrable brain disease, psychosurgery has little or no place.

What effect does psychosurgery have on psychopathic states, epilepsy, addiction, pain?

Its use is not established in psychopathic states, addiction, or behavior problems in epilepsy. Psychosurgery for intractable pain is an accepted procedure and still is regularly reported.

Why is psychosurgery chosen as a treatment?

It is a method of final resort and usually is chosen when other methods have failed or cannot be used.

Who is qualified to perform psychosurgical operations?

Psychosurgery is almost always the work of a neurosurgeon and a psychiatrist teamed together; one does the actual operation, the other

has responsibility for selection of patients and subsequent care. Each requires special experience for his part of the work but needs only general orientation in the other aspects.

Must permission be granted for the performance of psychosurgery?

Yes. Regular surgical permission is required as in the case of any operation. When the patient is mentally competent, he must give permission; otherwise, this is secured from the nearest responsible relative. A written form is ordinarily used.

What are the various surgical techniques employed in psychosurgery?

Many techniques have been used, but most of them fall into two classes:

- 1) those techniques that interrupt neuronal circuits by dividing the pathways that make up the white matter at the core of each of the two frontol lobes, and
- 2) topectomies, which remove various areas of gray matter in the frontal lobes or isolate them by deep cuts.

For the first group, approach may be from the side—the original prefrontal lobotomy—or from above with various modifications, or the transorbital approach, which passes an instrument into the brain directly through the conjunctiva above the eye and then the paper-thin bone that separates it from the underside of the frontal lobes. Cuts in the brain may be extensive or restricted, and the smaller cuts are now used for all but the most serious cases. Topectomies may remove larger or smaller blocks of tissue.

What complications might arise from psychosurgery?

Depending on the extent of the operation, the operative mortality usually amounts to some 2 to 3 per cent in the average series, although much better figures are reported. At some time, about 5 per cent or more of patients will suffer from convulsions due to brain scarring, and this will require anticonvulsant medication for control. All complications are much reduced in the small operations. Inertia is reported often, and gain of weight is occasionally a troublesome symptom.

What is the incidence of relapse following psychosurgery?

Relapse after remission in the first weeks or months is not uncommon. However, once a good degree of remission has been estab-

lished with independent living, results have been surprisingly stable, with only occasional relapse. A second operation can be done after relapse, but more commonly other standard methods of treatment are used and may be more effective than they were before the operation.

How long is the convalescent period after psychosurgery? Does the patient go through different stages of convalescence?

The convalescent period is highly variable depending on individual factors and very much on the type of operation and the nature of the illness. Favorable results continue to develop during the entire first year or even longer. At the start there is marked relaxation of tension, and the patient may show considerable confusion for days, weeks, or even months, but eats and sleeps well. Then there is a gradual resumption of better behavior patterns, a "washing out" of delusions and hallucinations or of the neurotic symptoms, and when the course is favorable these symptoms disappear completely. Return to fully independent living is a variable matter and may not be achieved in cases that have had a long preceding disability. When the family takes over the care of such a patient, it must be ready to provide the help that is necessary at the time and be able to see the entire process through, patiently and with adequate psychiatric guidance.

How does psychosurgery affect intelligence, creativity, personality, sociability?

Elaborate intelligence tests have failed to reveal any loss of intellectual capacity. Furthermore, it is extremely difficult to distinguish between the residual symptoms of a basic mental disorder and the possible aftereffects of the operation itself with regard to such characteristics as creativity. However, one does see at times a degree of social disinhibition and decreased sense of responsibility and consideration for others. This, however, is not the rule, and has been exaggerated. After the more limited operations, such complications are much diminished or absent. These matters are still largely matters of clinical opinion and are open to considerable variation of interpretation.

What conclusions can be reached about the results of psychosurgery?

At a time when no better method was available, psychosurgery made a very significant contribution to the care of thousands of cases of otherwise intractable mental disorders, returning approximately one-fourth of them to a degree of independent living and bringing signifi-

cant improvement to another 50 per cent. The price in complications and side reactions must always be weighed against the alternative of facing the uncontrolled effect of mental disorder, both from the point of view of the patient and of those interested in him.

How many psychosurgical operations are now performed in a year?

This is unknown. Probably only a few dozen.

What effect has the advent of tranquilizing drugs had on the frequency of psychosurgery?

After the tranquilizing drugs became available for general use around 1954, psychosurgery declined sharply and has now been virtually abandoned in most places. In New York State mental hospitals, 845 lobotomies were done in 1953, and less than 10 were performed in 1960.

What can be predicted about the prevalence, methods, and success of psychosurgery?

Barring some radical new discoveries, it seems safe to predict that a relatively small number of operations will continue to be done, using a variety of operations suited to the needs of different patients, with an emphasis on the smaller procedures, and that these will result in a good grade of remission in about 25 per cent of cases resistant to any other known procedure, with lesser degrees of improvement in another 25 to 50 per cent.

PSYCHOTHERAPY

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What is psychotherapy?

In its broadest sense "psychotherapy" is the systematic attempt of a trained professional person to relieve certain types of suffering by psychological means. The suffering is believed always to involve disturbances in the sufferer's feelings, thoughts, behavior, and relationships with persons important to him. All forms of psychotherapy attempt to give the sufferer an experience that will help him to overcome his fears, bolster his morale, and find more successful ways of coping with his problems. This experience includes a special type of relationship between the patient, or group of patients, and the therapist, and certain activities carried on jointly by them. These methods are believed to be therapeutically effective by them and the society in which they live.

What is the historical background of psychotherapy and who were some of the outstanding persons in its development?

Modern psychotherapies are rooted in two historical traditions of healing—the religiomagical and the naturalistic or scientific. The former, originating before recorded history, regards certain forms of suffering or of alienation from one's fellows as caused by supernatural forces or magical powers of sorcerers. Participation of the victim and his group in suitable rites under the leadership of a priest-physician might successfully combat these forces, restoring the sufferer to health and overcoming his alienation from family and friends. The tradition of supernatural healing has always been strong and finds its modern expression in healing shrines such as Lourdes, religious movements such as Christian Science, and numberless cults led by healers whose claims are accepted only by their devotees.

The naturalistic view regards illness as caused by natural forces. Treatment consists in combating these destructive influences by general methods for promoting bodily well-being and mental tranquillity, as well as by specific remedies. The same natural laws underlying bodily

illness are believed to account for mental illness, and the same general principles of treatment are believed to apply to both. The earliest surviving expression of this approach to mental illness is found in the writings attributed to the Greek physician Hippocrates, in the fifth century B.C. It was largely eclipsed by the religiomagical approach during the Middle Ages in Europe, but re-emerged and became dominant with the rise of science.

The man most responsible for the re-emergence of the naturalistic view of the cause and treatment of mental illness was probably the great French psychiatrist Philippe Pinel. At the turn of the nineteenth century he insisted that insanity was the result of excessive exposure to social and psychological stresses and he developed an elaborate descriptive classification of mental illnesses. He tried to help the insane regain their reason by "moral treatment," which included close, friendly contact, intimate discussion of personal difficulties, and a planned program of activities. These methods form the basis of psychotherapy today.

The emergence of specialized methods of psychotherapy can be traced to the dramatic demonstration by Franz Anton Mesmer in the middle of the eighteenth century that putting a patient into a trance might cause the disappearance of a wide variety of symptoms. Though Mesmer's particular theories and methods were soon discredited, mesmerism was the precursor of hypnosis, which today continues to be a widely used technique of psychotherapy.

Through the use of hypnosis, Sigmund Freud and Josef Breuer, toward the end of the nineteenth century, discovered that many of their patients' symptoms could be understood as efforts to resolve chronic conflicts that had their roots in upsetting experiences of early life. From these experiences Freud went on to develop psychoanalysis as a theory of human nature and a special form of psychotherapy. In its original form and in many subsequent modifications psychoanalysis dominates the theory and practice of psychotherapy in America today. (See *History of Treatment of Mental Disorders*)

It does not, however, have the field to itself. Its most important rival—the treatment of mental disorders by methods of retraining—springs from the experimental work of a contemporary of Freud's, the Russian physiologist Ivan P. Pavlov. He used conditioned reflex techniques to make dogs "neurotic" by exposing them to insoluble conflicts, and to cure them again, and his followers extended his ideas and methods to human beings.

Group methods of psychotherapy have come into increasing prominence since World War II. This development was hastened by the fact that there were not enough trained psychotherapists to treat privately all the patients who requested psychotherapy, and by the emergence of nonmedical psychotherapists who were not inhibited by the medical tradition of doctor-patient privacy. The recognition of the power of group forces to modify behavior and attitudes of individuals also led to the development of the principles of the "therapeutic community," which are revolutionizing mental hospitals. (See *Group Psychotherapy; The Therapeutic Community*)

Who is treated by psychotherapy?

Recipients of psychotherapy cover a very broad range, but can be conveniently grouped into five classes. The first consists of the hospitalized insane—persons who are so disturbed that they cannot perform the ordinary functions of living and need to be protected. The second class consists of neurotics—persons whose distress seems related to emotional strain based on unresolved personal conflicts. Akin to these is a third group, patients with so-called psychosomatic illness such as asthma and peptic ulcer, in whom emotional tension is reflected in specific disorders of body organs. The fourth group consists of persons who resort to socially unacceptable means of attempting to solve their personal problems, such as alcoholics, drug addicts, and sexual deviants. American society has not decided whether such persons should be treated primarily as criminals or as patients, and their proper handling is a knotty problem whose solution will continue to involve legal and corrective measures as well as psychotherapeutic ones.

Finally, there are the "minor maladjustments"—tired business executives, partners in unhappy marriages, unruly children, and the like. In this category may also be included persons with sufficient intelligence and leisure to worry about the meaning of life, who look to psychotherapy to resolve their spiritual unrest. (See *Neuroses; Psychoses*)

Who conducts psychotherapy?

The largest group of professionally trained psychotherapists are psychiatrists, numbering about 11,000. About two-thirds of these are in private practice, but less than 15 per cent work only in private practice. Approximately 10 per cent of psychiatrists have received special training in psychoanalysis, and there are also a very few psychoanalysts (lay

analysts) who do not have medical training. (See *Psychiatry*; *Psychoanalysis*)

Psychotherapy is also practiced by clinical psychologists, who number approximately 6,000, most of whom work in institutional settings, though an increasing number are going into independent private practice in the larger cities. A third group of professionals who practice psychotherapy are psychiatric social workers, numbering about 5,000. They function as members of treatment teams in hospitals and clinics under medical supervision, and in social agencies. A few are in independent private practice.

Many other professional groups practice psychotherapy in one form or another. These would include an indeterminate number of America's approximately 215,000 nonpsychiatric physicians, as well as osteopaths, and healers on the fringe of medicine such as chiropractors and naturopaths. Psychotherapeutic methods are also used by marriage counselors, clergymen in pastoral work, and other types of counselors. Finally, mention must be made of the thousands of religious healers who are members of established sects such as Christian Science, and religious cult leaders whose claims to healing powers rest solely on their own assertions, but who treat vast numbers of troubled people who are indistinguishable from those receiving other forms of psychotherapy. (See *Marriage Counseling*; *Pastoral Counseling*)

How can a person find a qualified and experienced psychotherapist?

Almost all qualified psychotherapists belong to professional societies. Directories of these societies can be found in most public or medical school libraries. Their national headquarters will supply information as to members in any particular location. They include the American Psychiatric Association, the American Psychoanalytical Association, the Division of Clinical Psychology of the American Psychological Association, and the Association of Psychiatric Social Workers.

Certain members of the American Psychiatric Association and the American Psychological Association are certified as specialists on the basis of special examinations. Such persons usually display their certificates in their offices; also, the names of certified psychologists and psychiatrists in your neighborhood can be obtained from national headquarters.

Further sources of qualified therapists are staffs of departments of psychiatry in medical schools, and staffs of state and veterans mental hospitals.

How is a person's background related to his ability to profit from psychotherapy?

Since most forms of psychotherapy depend on words, and since most psychotherapists tend to have middle- or upper-class values, poorly educated, lower-class patients tend to do less well than middle- or upper-class, well-educated patients, but there are many exceptions.

How are personal qualities related to one's ability to profit from psychotherapy?

Qualities that seem related to good prognosis in psychotherapy are good intelligence, some ability to relate to others, emotional responsiveness (if not excessive), feelings of distress and self-dissatisfaction, willingness and ability to talk about difficulties and weaknesses, and a value system similar to the therapist's.

Persons who do less well may have deep-seated character difficulties, sharply defined, persistent bodily symptoms, tendencies to isolate themselves, and sometimes a high degree of verbal facility in the absence of emotional responsiveness.

What are the chief characteristics of the psychotherapeutic relationship?

The therapist displays a serious, consistent interest in the patient's welfare. This enables the patient to develop increasing trust in him, leading to some degree of emotionally charged dependence. Supported by the therapist's understanding, nonthreatening attitude, the patient dares to let himself become aware of feelings and ideas that he has hidden from himself, to confide them to the therapist, and to experiment with new solutions to his difficulties. The therapist guides this process more or less directly, depending on his therapeutic method.

What are the major psychotherapeutic methods?

Psychotherapeutic methods may be classified according to whether the patient is treated privately or as a member of a group, or whether the focus is on the group to which the patient belongs. The last type, of which the therapeutic community is an example, tries to help the patient by creating a special type of total environment and therefore requires an institutional setting. In the first two types, treatment contacts between patient and therapist are intermittent, and therefore can be used with outpatients, as well as hospitalized ones.

Both individual and group therapies may also be classified as evocative and directive. (See *The Therapeutic Community*; *Group Psychotherapy*; *Family Psychotherapy*)

What are the characteristics of evocative therapies?

Evocative therapies try to create a situation that will evoke the whole range of the patient's difficulties and strengths, thus helping him not only to work out better solutions to the problems bringing him to treatment, but also to develop greater self-insight, maturity, and inner freedom. Emphasis is on the patient's gaining self-understanding. Therapeutic goals are open-ended, and all aspects of the patient's present and past life, including his feelings toward the therapist, may come under review. Therapy usually comes to focus on specific issues, themes, or habitual ways of dealing with problems that recur in many different situations. As they are repeatedly explored in different contexts, the patient may be enabled to understand and modify them. (See *Insight*; *Existential Therapy*)

What does the patient do in evocative therapies?

He sits in a comfortable chair or lies on a couch and tries to express his feelings, thoughts, dreams, and fantasies as honestly and completely as he can. These may involve the therapist. The patient may be asked to say whatever comes into his mind (the method of free association), or he may express himself in more organized fashion.

What does the therapist do in evocative therapies?

He listens and tries to ask questions or make comments that show he understands, and that encourage the patient to express himself. He also offers interpretations of the patient's statements and behavior that he believes will help the patient to understand himself better.

What are some major forms of evocative therapies and how do they differ from each other?

The features mentioned in the immediately preceding sections are shared by all evocative therapies. There are, however, several "schools" that differ in their conceptualizations of mental illness. This leads to differences in the kinds of patients' statements that are emphasized and in the ways they are interpreted.

Most schools grew up around early students of Freud who developed

ideas differing importantly from those of their teacher and who acquired coteries of followers. Some went on to develop training programs representing their viewpoints. Freud regarded neurotic and psychotic symptoms as expressions of, and attempts to resolve, more or less unconscious conflicts springing from early disturbing life experiences; hence he and his followers stressed exploration of the patient's past and utilized dreams and fantasies as means of understanding the patient's unconscious. Carl Jung developed an elaborate theory of personality in which the unconscious of the individual was viewed as an expression, in part, of a collective unconscious, which was a great reservoir of creativity. Thus, he used dreams and fantasies to illumine the workings of the collective unconscious in the patient and emphasized freeing his creative capabilities. Alfred Adler conceptualized neuroses as growing out of feelings of inadequacy, which hamper the patient's attempts to achieve a fully satisfying social adjustment. This led him to emphasize the patient's self-image, his goals in life, and his characteristic ways of handling his relations with others. Karen Horney, Erich Fromm, and Harry Stack Sullivan, with slight differences in emphasis, also stressed the part played by psychiatric symptoms in maintaining faulty patterns of interpersonal relationships, and stressed treatment focused on the patient's present modes of functioning, rather than on their historical or unconscious sources. (See *The Unconscious*)

As schools originating with Freud were emerging in Europe, Adolf Meyer in the United States was promulgating his so-called psychobiological approach. To him, mental illnesses were faulty reaction patterns or habits of response to others, based on hereditary handicaps as well as damaging life experiences, and involving bodily as well as mental functions. This view was reflected by a therapeutic approach that took into account every aspect of the patient's functioning—a "distributive analysis and synthesis" aimed at helping him to avoid "what doesn't work so well" and to make the most of "what works." More recently in the United States, Carl Rogers developed an approach that relies exclusively on the ability of the counselor to understand and feel with his client, without offering any interpretations, as the chief source of the patient's ability to change.

The distinctions between the different schools are becoming increasingly blurred as their founders recede into history. Recognition of their essential similarities has been fostered by the growing realization that in their actual conduct of therapy, psychotherapists of different schools behave in much more similar fashion than their public state-

ments would suggest. All schools regard the therapeutic relationship as creating an emotional climate favorable for change, which is mediated by self-awareness or insight. For all, the goal of therapy is to enable the patient to modify ingrained faulty patterns of feeling, thought, and behavior in such a way as to improve his ability to get along with others, thereby gaining increased feelings of security and satisfaction. Thus, conceptually, the different schools are not only moving closer to each other but are also moving closer to directive therapies based on learning theory.

What are the characteristics of directive therapies?

Directive therapies try actively to relieve the patient's symptoms or to correct maladjustments. Goals tend to be sharply focused, and the patient's past is reviewed only sufficiently to enable the therapist to devise a plan of treatment. The therapist assumes active leadership and may use a variety of special techniques. In keeping with differences in their goals and approaches, directive therapies tend to be briefer than evocative ones.

What are some forms of directive therapy?

No one form of directive therapy in the United States has a very large following, and any therapist may use a variety of techniques. These include hypnosis, relaxation exercises (which may also be used in evocative therapies), exhortation, advice, persuasion, desensitization to anxiety-provoking thoughts or memories, and insistence that the patient do the things he fears. (See *Hypnosis*)

What happens in directive therapies?

The patient tries to follow the therapist's instructions to the best of his ability, with respect to his behavior both during the interview and outside. When there is a change in his behavior toward others, he reports the results to the therapist at the next interview. On this basis the therapist gives further instructions.

How frequent are psychotherapeutic interviews?

This depends on the therapist and his method. Intensive evocative therapies usually have three to six sessions a week. The most common interval is probably once a week, but even interviews as infrequent as once a month may sometimes be very useful.

How long does psychotherapy take?

Within wide limits, the length of a course of psychotherapy seems to depend primarily on what the therapist leads the patient to expect. Sometimes a single interview may suffice. At the other extreme, a psychoanalysis may continue for several years. On the average, directive therapies usually last less than three to six months. There is a little evidence that evocative therapies may require an average of at least eight months to reach full effectiveness.

Can a patient judge his own progress in psychotherapy?

Yes, to a large extent. He is the best judge as to whether he is feeling or functioning better. However, sometimes an increase of anxiety or depression may precede improvement, or a patient may fool himself into thinking he is better so as to escape further treatment. In these circumstances the therapist may be a better judge of the patient's progress than the patient.

How is termination of therapy decided?

Ideally, by mutual agreement of patient and therapist that the former has made progress sufficient to warrant termination of treatment.

What is the status of psychotherapy in the United States today?

It is very much in demand, especially in urban areas, and the demand seems to increase with the supply, so that demand always exceeds the capacity of available trained therapists to meet it. At the same time, many segments of society view psychotherapy askance, and many persons are reluctant to seek it, feeling that to do so would be a sign of moral weakness.

In response to the demand, the National Institute of Mental Health sponsors extensive training programs for psychiatrists, clinical psychologists, psychiatric social workers, physicians who wish to receive psychiatric training, and others. Government and private sources are also pouring millions of dollars into the support of research in this field. In time this should afford a more solid basis than exists at present for evaluating the mode of operation and the effectiveness of various forms of psychotherapy.

REHABILITATION OF THE MENTALLY ILL

by MILTON GREENBLATT, M.D.

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What is "rehabilitation of the mentally ill"?

For some workers in the mental health field, rehabilitation is restoration of occupational capacity; for others it is synonymous with total treatment. Physical rehabilitation, which preceded mental rehabilitation, concerned itself primarily with preparing a handicapped person to take a job. Mental rehabilitation experts have tended to broaden this definition, keeping as the central theme the importance of occupational self-sufficiency but laying emphasis on enhancing all the capabilities of the individual. Because its scope is not agreed upon, and it may be used to apply to goals, processes, or results, the term "mental rehabilitation" needs further definition and clarification.

What areas of patient functioning require special attention in mental illness rehabilitation?

There are six principal areas to which rehabilitation efforts may be applied. These are: (1) psychological, (2) vocational, (3) family, (4) social-recreational, (5) community, and (6) educational. Mature individuals function comfortably and efficiently in all six areas; most sick individuals, however, show impairment or deficiencies in one or more of these areas. Degree and pattern of impairment vary for different illnesses. Functions tend to be interdependent. Usually the more severe the defect in one area, the greater the probability of impairment in another. This is particularly true in the psychological sphere. As a rule, patients severely handicapped by interpersonal tensions, inferiority feelings, or behavioral disorganization show poor occupational adaptation, while the family, social-recreational, community, and educational adjustments also are often disturbed. The chronic schizophrenic patient, for example, is often severely limited in all areas; the

average neurotic, on the other hand, may have functional deficits in only a few areas. For each mental patient there is a characteristic profile; the job of rehabilitation is restoration to maximum efficiency in all areas. (See *Schizophrenia; Neuroses*)

What are the rehabilitation problems and techniques in the various areas?

Psychological rehabilitation is of paramount importance in mental rehabilitation. Here the problem is reduction or removal of clinical symptoms—anxieties, tensions, conflicts—that set limits to the patient's ability to grow or to enjoy life. This requires individual or group therapy after careful psychodiagnosis has established the patient's focal conflicts, his strengths and weaknesses, and set realistic goals. A psychiatrist, or, under his guidance, a social worker, psychologist, or other member of the treatment team, should undertake psychotherapy. In severely regressed patients the process may take years, requiring a therapist especially devoted to the patient, generously endowed with patience, and inured to setbacks and frustrations that often obstruct the way. (See *Anxiety; Psychotherapy*)

Vocational rehabilitation involves assessment of current and possible occupational interests and capacities, training to develop old or new skills, actual trials at appropriate work with gradual adjustment of conditions to approximate community work, assistance in job placement, and a follow-up to cushion stresses and strains on the job and prevent a relapse.

Is vocational rehabilitation an individualized procedure?

Like psychological rehabilitation, vocational rehabilitation is highly individualized. In this area there is much need for experienced persons or specialists. For example, in the hospital the rehabilitation counselor or special therapist may undertake assessment of the patient's work problems and needs, and formulate prescription in consultation with a psychologist, a social worker, or a nurse. The first steps toward useful activity may be taken in the ward under the guidance of the nurse or in the occupational therapy department under the tutelage of a trained occupational therapy worker. Perhaps later the patient is assigned to appropriate hospital industry, where the industrial supervisor gives him orientation, instruction, and guidance. Then the rehabilitation counselor helps the patient plan his search for a job in the

community. Here, contact with industry may be crucial in opening up suitable places for the patient to try out skills. Continuation of counseling at this stage may be vital to meet stresses associated with any condition of employment.

Who coordinates all this?

Leadership varies depending on the treatment philosophy, available personnel, and many practical considerations. Often the psychiatrist coordinates the efforts; sometimes an administrator or special therapist is appointed. Where psychiatrists are unavailable or are concentrating their efforts on psychotherapy, nonpsychiatric professionals such as rehabilitation counselors, social workers, and special therapists may take over the coordinating functions.

Is there some order of importance or emphasis guiding the use of different rehabilitation techniques?

Individualization is the keynote. However, no one could neglect family rehabilitation as an essential facet of total rehabilitation. The family is receiving increasing attention in modern times, not only because it is often the breeding ground for psychiatric disorder, but also because so many patients must return to their families once their illnesses have abated. Often the breakdown of one member is a reflection of tension, discords, and feuds that have been going on for years within the family circle. Not infrequently other family members are suffering from character disorder or neurotic difficulties, unrecognized and untreated. Rehabilitation effort of considerable magnitude can be vitiated if a patient returns to a psychopathological family situation that engendered the breakdown in the first place.

The psychiatric social worker has gained a great deal of experience in working with the family. Often family living conditions or specific social or psychological problems require investigation, especially where the patient is responsible for young children. The social worker may help family members to accept the patient's illness, his hospitalization, and treatment plans. She may carry on individual therapy with the patient in the area of his adaptation to the family or, on the other hand, with important family members who hold the key to acceptance of the patient.

In treating psychiatric disorders of children, it is customary to involve the mother in professional treatment too, often with a social worker, on the basis that most childhood disorders reflect difficulties

in the mother-child relationship, although it may involve other family members as well.

In recent years important explorations have been made in family therapy in a broader sense. Several variations have been tried, for example, gathering the relatives of patients in group sessions, sharing common problems in relation to hospitalized family members, or working with the whole family group, including the patient and his immediate kin. All reports indicate the great value of such experiences to family members; some colleagues predict that psychiatric treatment of the future will not be individual, but will be a family affair. (See *Family Psychotherapy; Childhood Emotional Disorders*)

Why are social-recreational, community, and educational rehabilitation important?

Experience indicates that social-recreational and community adaptation are very weak areas of adaptation of the sick individual, yet very little treatment effort is ordinarily directed toward them. For a great many patients, relapses are likely to occur where community roots are undeveloped or superficial, or where social and recreational satisfactions are inadequate. The ex-patient, for example, may make a fairly adequate psychological recovery, hold a job, and perhaps improve his relation with his family, yet he may be afraid to face his friends or community group, fearing stigmatization and rejection. Sometimes the difficulty is lack of suitable social-recreational groups—"halfway groups"—with tolerance for the patient's social and other handicaps.

Educational rehabilitation refers to the growth of the individual both through important life experiences and via formal or structured educational programs. Perhaps one of the most profound educational experiences anyone can undergo is that of having lived through a mental illness. Those who have successfully integrated these experiences may be among the most sensitive, thoughtful, and understanding individuals in our society.

Many mental hospitals have taken a real interest in advancing the educational status of their patients, offering broad programs of art, music, language, dance, photography, carpentry, cabinetmaking, and lectures by knowledgeable citizens. The discovery and development of new areas of curiosity, competence, or striving may be a profoundly enriching experience in the patient's life and contribute greatly to his overall happiness.

What is the earliest point at which rehabilitation can begin?

In a sense rehabilitation begins with the encouragement of the proper conditions for mental health, that is, by rearing infants in stable and affectionate families without serious physical or economic privation, with satisfactory play life and good conditions of schooling. The average individual, however, receives professional attention only when he manifests symptoms out of harmony with his previous conduct or disturbing to his family or society. Here the alertness of the family doctor, religious adviser, schoolteacher, or visiting nurse may go far toward early case detection and diagnosis. The paths of patients with developing illness are very complex. Not infrequently unnecessary delays occur or bad decisions are made because the problem is first placed in the hands of lay persons lacking expert knowledge. Early medical-psychiatric consultation may be provided by community mental health clinics and organizations, or by referral to a hospital outpatient service. Recent experience indicates that many patients who were formerly hospitalized can be managed through an outpatient service providing psychotherapy and somatic therapy, and utilizing community agencies, without necessity for hospital admission. In fact, even in seriously ill cases, between 50 and 60 per cent can be handled successfully outside the hospital.

Is hospitalization something to be avoided at all costs?

Hospitalization, like any important step in the patient's life, may have therapeutic or harmful features. For some patients and families, hospitalization means separation from family and community, removal to remote institutions, deprivation of many civil rights, limitation of physical mobility, and relegation to an environment characterized by sickness, drabness, monotony, and boredom. For other individuals, the hospital is a haven, an institution providing therapeutic facilities unmatched by any extrahospital environment. However, in the future it is entirely likely that more and more efforts will be expended toward keeping the patient out of the hospital, if possible, and placing a large part of the responsibility for management in the hands of general practitioners with guidance from hospital personnel. In England many hospital psychiatrists spend a large portion of their time in the community, treating patients in their natural environment. We expect a growing number of clinics in the United States and abroad to explore alternatives to hospitalization and to set up facilities that can be utilized

both as a transitional place for discharged patients and to prevent hospitalization.

Obviously, the management of the early phase of illness before hospitalization depends largely on the degree of enlightenment about mental illness possessed by leading community figures to whom persons in distress normally turn for aid. Particularly in this category are ministers, teachers, employers, and personnel officers, as well as welfare workers. The improved training of practitioners in psychiatry in medical school, and their continued education when in practice, would greatly enhance the opportunity for early rehabilitation of the mental patient. (See *Mental Hospitals; The Mental Patient; Hospitalization*)

What are the rehabilitative aspects during hospitalization?

In the hospital a great many rehabilitative influences can be brought to bear on the patient. The emphasis is on creating the best possible therapeutic climate for the patient and to administer to his particular needs. In a therapeutic climate or "therapeutic community," attitudes of the personnel are very important; they should be accepting, sympathetic, and for the most part, uncritical. Here individual and group psychotherapy may be coordinated with a broad program of social-recreational activities, work therapy, and a variety of somatic treatments. Physical or physiological handicaps may be corrected. The goal is to restore as early as possible the functional capacities so that the patient may quickly enter into the transitional phase. (See *The Therapeutic Community; Group Psychotherapy*)

How does the hospital program respond to different types of cases?

Perhaps a few brief illustrations would be helpful.

Case 1: Mary S., a middle-aged housewife, mother of two grown children, has been overcome by a typical mid-life depression after the recent deaths of her husband and her father and the "loss through marriage" of two daughters, both of whom have recently moved away from the home. This woman had been extraordinarily efficient and conscientious throughout her life, having expended the major part of her energies in service toward others. With no one to look after, and two bereavements, she has succumbed to a clinical syndrome of tension, agitation, fear of the future, and numerous bodily complaints. For such a person the hospital program emphasizes the development of a strong, stable, personal relationship, perhaps with a male figure of her own age range, i.e., intensive individual psychotherapy. At the same

time, the patient is encouraged to join groups and to begin the slow process of broadening her friendship patterns, which have been mostly curtailed because of the demands of her home. During hospitalization an intensive survey of the patient's interests and skills reveals that before marriage she had been an efficient secretary in a large organization. She is given the opportunity to refresh her secretarial skills and is tried out as auxiliary secretary to one of the hospital departments. Gradually hours of work are built up to approximate the outside. Numerous consultations are held between work supervisor and rehabilitation counselor, resulting in considerable help to the patient in her psychological adaptation to the job situation. Gradually the patient sees the rehabilitative value of a job in the community. Upon discharge, arrangements are made for her to live with one of her daughters, then to set up independent existence, obtain a job, make new social contacts, and join women's organizations. The follow-up, a year and a half later, shows that our patient has once more a sense of usefulness, has made new friends, many of them among widowed women with similar problems, and has a renewed interest in life with a sense of purpose and self-esteem.

Case 2: By contrast there is Fred W., a teen-ager of fifteen, who has reacted to family discord by a great slump of interest in school, by late nights, and occasional runaways. Here, too, an intensive relationship with a therapist is important, as well as healthy group activities with other adolescents. In this instance both parents become members of a parent group to discover their contribution to the patient's difficulties. Inhospital schooling under special tutors continues the patient's education. On discharge, the emphasis is on reestablishing the home, developing contacts with a supervised local boys' club, and new interests, such as electronic building, consistent with areas of aptitude discovered while in the hospital school.

Are the same measures used for patients who have been hospitalized for a long time?

Here the pattern differs. For such patients the retraining starts at a very elementary level. In addition to individual therapy, where even the toleration of one person, week after week for many months, may be a very great problem, the patient must learn such simple things as how to shop, how to make change, how to dial a telephone, and how to travel via public conveyances.

With the chronic patients great emphasis is placed on the use of

transitional facilities, such as day hospitals, halfway houses, etc., and on aftercare. For many, it is vital that they receive tranquilizing medication under adequate supervision for many months. The social worker has a special function in helping the family accept the patient and in assisting the patient in finding an adequate role for himself in the community.

How does rehabilitation help with the problems of the transitional phase?

The transitional phase is especially significant because many patients find the step from hospital to community too great for successful negotiation. Patients who have been hospitalized for long periods, whose families are not warmly accepting of them, or who have no family to go to are especially vulnerable. Thus, a variety of facilities have evolved that have potentially great value when properly used.

The best known of the facilities are:

The Day or Night Hospital. The day facility has been developed to encourage early separation of patients from the hospital; they receive treatment in the hospital by day but return home to sleep at night. This is especially suitable where the home environment is too difficult to endure for the full day, where patients are as yet unable to work outside, and where long-term contact with the "therapeutic climate" is advisable. Night hospital patients, by contrast, work in the community during the day but return to the hospital overnight.

The Sheltered Workshop. This has been found helpful in the rehabilitation of many patients. It best follows a well-developed work program within the hospital. Additional work training and work "hardening" can occur within a sheltered workshop situation where, gradually and progressively, conditions of industry can be approached.

The Halfway House. This refers to a community residency situation, usually under the guidance of experienced personnel, for patients who might profit from group or dormitory living and who can earn and help pay for their maintenance. Patients who have no home to go to or who cannot anticipate comfortable acceptance in a home may do very well in a halfway house as a transitional measure.

Family Care. Especially for chronic patients, family care programs may be very successful. The patient is placed with a selected family that accepts him as a boarder who often works and contributes to the group living. The state or philanthropic agency pays expenses, and the hos-

pital maintains a watchful, supervising function through a social worker or a public health nurse.

The Ex-patient Club. Patients and ex-patients are able to band together successfully in their own interests. Inpatient self-government is a gratifying actuality in many hospitals, and ex-patient clubs are increasing in number and variety throughout the country. In ex-patient clubs former patients have an opportunity to participate in many group activities and thus gain assurance and confidence in social situations. Club membership may be a stepping-stone to developing more secure community roots and thus may play an important role in the prevention of relapse.

Outpatient Therapy. This is a growing service that proves invaluable to many ex-patients who need long-term supportive or analytic therapy, group work, or a course of pharmacotherapy or electric shock treatments. Outpatient therapy constitutes a major bulwark of support and a line of defense against rehospitalization.

Are the transitional facilities used in various combinations to suit the individual case?

Transitional facilities should be used in the pattern best suited for the individual patient. Worth emphasizing, too, is that once established, these facilities may be used as alternatives to hospitalization for patients who suffer a worsening of illness, or even for those who suffer a first attack of illness. Such facilities may be the great preventives of hospitalization for patients of the future.

However, many patients need additional support and encouragement for the stresses of relating to other citizens. Job finding, because of the stigma of mental illness and serious inferiority feelings, may be a special problem. Family hostility and anxiety may be such as to require special social work counseling or home visits. The hospital has a very special responsibility to educate citizens and employers to increase their understanding and receptivity of mental illness. The hospital may also encourage community initiative, offering guidance and collaboration with agencies in a series of flexible arrangements. (See *Mental Health Services in the Community*)

What is the role of drugs in rehabilitation?

Chronic patients, in particular, require drugs under supervision, for long periods of time. Recent studies indicate that relapses may thus often be avoided. Severity of symptoms may be diminished, hospital-

ization reduced, and socialization enhanced by modern tranquilizers in a variety of illnesses. (See *Psychopharmacology*)

How successful are rehabilitation efforts?

Reliable figures are difficult to obtain. The following impressions, however, are probably close to the truth:

1) Hospitalization could have been prevented for at least 50 per cent of the patients now being admitted.

2) At least 80 per cent of acute patients (sick less than a year) admitted to the hospital may be discharged under conditions of intensive care and treatment within four months. A moderate percentage of the remainder may be discharged within one and a half years. These figures apply mainly to younger individuals suffering from psychoses or severe neuroses.

3) Probably one-third of the chronic cases, perhaps more, could be rehabilitated to some level of satisfactory community adjustment, although not necessarily full independence, with vigorous rehabilitative methods.

4) Long-term follow-up statistics available for hospitalized acute cases indicate that 75 to 85 per cent are still in the community during the fifth year following discharge.

5) A two-year follow-up of acute cases (men) indicates a high level of full reemployability, approximately 75 per cent, in times of a good labor market.

6) The relapse rate on an annual basis was formerly 25 to 30 per cent, but has been reduced considerably in recent years where institutions offer aftercare facilities.

Is the public generally aware of the hopeful outlook for the mentally ill?

Not only the public, but many members of the medical profession do not as yet appreciate how much can be done for the mentally ill when proper conditions are provided.

Is there a growing interest in and support for mental rehabilitation?

Very much so. In England and the United States, distinctions between physical and mental rehabilitation have been erased insofar as governmental support and financing are concerned. In the United States, major advances have been made through the Office of Vocational Rehabilitation of the United States Department of Health,

Education, and Welfare, and the various state divisions of rehabilitation. Many new and promising methods of treating mental illness are being investigated through the support of the Office of Vocational Rehabilitation and the National Institute of Mental Health, as well as through private foundations and business organizations. The states are spending an increasing amount of money for community mental health services designed to treat and hold patients in the community. In 1959, the states alone spent an estimated \$37,000,000 in support of these services as compared with only \$5,900,000 in 1952. Most encouraging of all is the ground swell of citizen interest and participation. In many communities one finds real initiative in establishing mental health agencies of various sorts. The state associations for mental health and the various groups aiding the retarded or emotionally disturbed children are good examples of a large and growing responsibility of citizens for mental illness and health. (See *Mental Retardation; National Association for Mental Health*)

RELIGION AND PSYCHIATRY

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Are the tenets of religion and the principles of psychiatry in basic conflict?

Both religion and psychiatry are areas of concern so broad and general that one would be surprised if somewhere within the scope of each, one could not find some aspect that would clash sharply with an aspect of the other. This likelihood is underscored by the fact that within each of the fields themselves, there are seriously divergent opinions.

The question might be rephrased as follows: Are the broad, generally shared attributes of major American religions in serious conflict with the central core of generally accepted psychiatric principles? To this question the answer would be, "Generally, no." In other words, some of the very forces of syncretism (the tendency of two points of view to come together) that have made American religion a unique blend (see Will Herberg's *Protestant, Catholic, Jew*) have been at work in American psychiatry, which has tended to harmonize and combine a number of strains into a central group of major tenets that are accepted by most American psychiatrists, or so it seems.

Religion and psychiatry may be expected to agree in three areas: (1) Does religion have a right to an opinion about man's nature and destiny that is unprovable by science or contrary to science? Where such ideas are held, in addition to those about God and the nature of the universe, can they be considered signs of personal or group abnormality, immaturity, or neurosis? (2) Does science have a right to make philosophical judgments in areas where it cannot observe or experiment? How dare a scientist cast doubt on belief in God when he is in no position as a scientist to test this concept? (3) Is the psychiatrist's view of moral deviation as a symptom rather than as a sin, an indication that he really has no morality, and is therefore an enemy of the morality of religion?

With what areas of psychoanalysis does religion disagree?

Some representatives of various religions have taken issue with psychoanalysis in almost every area of its interests and concerns. They have objected to Sigmund Freud's opinions that religion is nothing but "an infantile or neurotic remnant." They overlook the fact that Freud also recognized that for the existence of most people and for the maintenance of civilization, religion played a major role; also that within religions was embodied priceless information about man's nature and telling insights about important psychological issues.

Others have found fault with the theories of analysis about man's nature, his sexuality (particularly his childhood sexuality), his irrationality (forgetting that Freud also recognized the importance of the reality principle, a more rational aspect of man), and his aggressive drives (again, particularly, in childhood, and toward loved ones). Still others suspect that in analysis, the encouragement of free association of ideas extends into expressed or implied permission for the patient to act on his impulses regardless of social or religious conscience to the contrary. This too is a misunderstanding and is contrary to all sound analytic practice.

Another objection is to the attachment between the patient and the doctor, the "transference." This is feared to be conducive to improper relations between them (a risk fully recognized and stringently guarded against by analysts), or to the patient's substitution of the analyst for family, friends, or his religious ties, with detrimental results (again, this is a temporary tendency, not encouraged by analysts, but accepted and gradually dissolved as the analysis approaches successful termination). (See *Psychoanalysis*)

What goals and activities do religion and psychiatry have in common?

(1) The development of healthier individuals and groups, who will be more free to know and recognize themselves in their fullness, including their feelings, thoughts, fantasies, wishes, and fears, and their potentials and capabilities; (2) the development of their capacity for self-direction, with resulting freedom from bondage to the irrational and the infantile; (3) the development of family and group life conducive to rearing and supporting new generations who will be characterized by greater honesty, less confused loyalties, less ambivalent capacities to love, act, work, play, hope, and trust; (4) the possibility of developing

more compassion for the suffering, more understanding than censure for those in need of help, and increased recognition of subtle forms of man's inhumanity to man, and of the necessity that they be avoided; (5) the fostering of generations capable of considering seriously the major issues of life, despite their unpleasantness, of acting with courage and forthrightness, with love and honesty; (6) the recognition of the part each of us plays in the lives of others and of the need for improvement of our contributions to their welfare; while at the same time recognizing the limits of our powers and rights in the lives of others, so that without guilt or shame we are able to relinquish claims and controls and to allow them to develop as individuals, despite their non-acceptance of our own preferences for them. (See *Morals, Values, and Mental Health*)

In those areas where there might be conflict, can a deliberate decision to avoid certain issues be made in good conscience?

A psychiatrist works against serious obstacles when he treats a patient who has personal or religious mental reservation. Often it is precisely the areas the patient tries to withhold from scrutiny that have vital relevance for successful treatment. It would be better for such a patient openly to indicate his areas of concern in advance and to allow himself to be reassured that the psychiatrist has no ulterior designs upon the valid core of his central values but has only the desire to assist in honest understanding of the meaning of such values in the life of the patient. If the disagreement is seen in advance to be irresolvable, then the patient should be referred to a psychiatrist with a more open-minded attitude toward these values.

By and large, competent psychiatrists do not allow their own preferences for a given set of moral norms or of philosophical and religious orientation to influence a patient one way or the other. They try neither to intensify nor to overthrow the patient's religion or morality, to the extent that it is genuine morality and not just a private whim. In some circumstances it may be preferable for both the patient and the psychiatrist to be of the same culture and faith. Usually, in this author's opinion, this is not necessary and sometimes not even desirable, particularly if the patient imagines that the therapist is sitting in judgment on his failure to live up to the beliefs and practices of their common faith. Here, a more neutral person may be more helpful in assisting the patient to examine the healthy, and the neurotic, roots of his belief

and practice and to sort them out in the service of maturing as a person and as a member of a faith community.

Are certain psychiatric theories less in conflict with religion than others? Which ones? Why?

Probably two groups of theories conflict less than others: those that do not seem to concern religion directly (for example those dealing with organic functioning of the nervous system), and those that happen to reinforce ideas already believed by religious groups (for example, that parents play a great role in the character development of children; that love is necessary to the growth and survival of man; that honesty is better than hypocrisy; that the man who claims he is without blemish is in more trouble than the man who honestly admits his faults and troubles; that both compassion and firmness are necessary in dealing with deviant behavior; that life consists of more than bodily functions, but rather includes hopes and fears, images and goals). Actually a good many psychiatric tenets seem self-evident even to persons first hearing of them: they fit in with common sense, the lore of religion, drama, literature, and the arts, and hence are common property. Psychiatry tries to explain these tenets and fit them together into coherent theoretical formulations, whereas the general public usually takes them for granted.

Do any religious groups absolutely oppose psychiatry?

No major religious groups oppose psychiatry as such. Some Roman Catholics once were given to understand that a great deal of psychoanalytically derived psychotherapy was contrary to religion. But even this opposition was not official, and was not advanced by the church as a whole. Some small fundamentalistic sects have opposed psychiatry except in cases of organic brain disease or open psychosis (open insanity), where even these sects have accepted psychiatry as a sort of necessary evil.

Can the terminologies that religion and psychiatry employ stand as barriers between the two?

Terminology stands as a barrier between humanistic disciplines and the sciences, between religion and the behavioral sciences, and between professionals and lay people. More and more all these groups are trying to develop simpler and more consistent language in order to

avoid appearing to differ unnecessarily. An example is the word "ego." To some people this word is connected only with the idea of overweening pride, with egotism. In psychiatry the word means an agency of the personality that functions to coordinate the individual within his own mind and within his culture. It has no overtones of selfishness, pride, or arrogance. Another example is that of the word "conversion." In religion it refers to a change of religious orientation; in psychiatry it refers to the turning of energy from one psychological direction into another, but with no religious overtones. The phrase "conversion hysteria" therefore does not imply that conversion is hysterical, but that a given hysterical symptom or group of symptoms came about through a person's unconsciously redirecting his energies from one body or mental system to another, causing dysfunction of the affected area.

How does psychiatry view the religious concepts of sin and guilt?

There is no one position in psychiatry at large. Psychiatrists do not pretend to be competent to decide what is, or whether a given act is, sinful; this, they insist, is the responsibility of a theologian or spiritual counselor. They do use the word *guilt*, and some of them make the distinction between guilt, and guilt feelings. The former refers to violations of moral codes; the latter to the feeling of apprehension and expectation of punishment for real or imagined violations. If the two correspond, a person is said to be normally guilty. A real infraction is followed by real guilt. If the two do not correspond, one may have two abnormal possibilities:

(1) There may be a real infraction, but no evidence of remorse or sense of guiltiness. Usually it can be demonstrated that such guilt feelings are unconscious and unrecognized; they may even express themselves in indirect ways leading to the person's punishing himself or seeking punishment.

(2) There may be guilt feelings, conscious or unconscious, but no real infraction. These feelings are not related to their alleged source, and the person blames or punishes himself unjustly. It may be that he feels guilty for a thought or feeling that in religion would not be considered a sin, or in law would not be considered a crime. But in his private world, he treats a wish as if it were an act, and punishes himself as if he had committed a real crime. It may be that he is guilty of a long-forgotten act and is replacing the real source of his guilt with another source—a red herring.

It is the job of the psychiatrist to help straighten out these confusions,

to help his patients know why they feel guilty when they shouldn't (or when they feel guilty for the wrong reasons), and to help them feel appropriate guilt for the real acts that violate their own or society's codes. Only in this way is there the possibility of their guilt feelings helping their ethics. (See *Guilt*)

How does psychiatry view the concepts of conversion and salvation? Of good and evil? Does it make any use of these concepts in its theory or practice?

Psychiatrists treat *conversion* and *salvation* in their theological meanings as outside their domain of definition. They do seek to understand how their patients view their experiences and to clarify their patients' perceptions toward integrating those experiences into their whole personalities. Psychiatrists, like many ministers, priests, and rabbis, are suspicious of a sudden conversion that seems to be more a psychopathological than a spiritual experience. This is partly because such an event sometimes immediately precedes a severe mental breakdown or occurs during one. On the other hand, many psychiatrists have observed the integrating effect of a religious conversion in which a person comes to see his whole life in focus and begins to live toward a clear future. Too little is known of the differences between the disintegrating and the integrating types of conversion experience. Anton Boisen, in *The Exploration of the Inner World*, has dealt extensively with this problem.

Some theologians and pastors have a global view of salvation that comes close to personal wholeness: psychological, physical, and spiritual. Some psychiatrists hold a somewhat similar view. These representatives of the two fields find much in common in their understanding of the transformation of a sick, sinful, and confused life into one with health, wholeness, and holiness. Nevertheless, these representatives of both fields are probably in a minority. The majority of psychiatrists would leave the word *salvation* to the theologians. They are not unaware, however, of the importance of salvation experiences in the lives of their patients, or of the craving that besets so many persons today, to find a meaning and purpose in life.

Good and *evil*, as technical terms, tend to be avoided by psychiatrists, who do not set themselves up as competent to rule on objective ethical issues in a philosophical sense. Generally they try to help the patient find out what he means by his use of such words and to explore the implications and consistencies in the words and their attachments to

acts and feelings. By and large, psychiatrists discourage a patient from thinking of his thoughts or feelings as evil, suggesting rather that they are neither good nor evil, but, like the body temperature or other physical functions, that they tell us something about our inner state and our relation to our past, present, and future.

With regard to actions, psychiatrists tend to regard as good those that are authentic (not artificial or assumed), effective (not fruitless or self-defeating), integrated with the community of choice (not meaninglessly rebellious or incoherent to others). They have ideas concerning what is good and evil for themselves or society, but they try to elicit the patient's own understanding of what is good for him, rather than to impose their own notions. They also help the patient to examine the norms and expectations of those with whom he relates, so that he will have less confused ideas about their relation to his own norms and expectations.

Like all physicians and most helping professional persons, psychiatrists say little about ethics. There are certain obvious but unspoken assumptions, which include the following: health is better than sickness; a doctor should not exploit his patient, but should help him; honesty is better than deception; the individual is to be valued, and his needs, feelings, ideas, and wishes, no matter how different from the doctor's, must be taken seriously; individuals must live in community and they must understand the pressures and expectations upon them and find a workable solution that is neither destructive of the self nor of others. All of these values have historical connections with the great religious and philosophical systems. They are not, however, openly talked about very often either among psychiatrists or between psychiatrists and patients; rather they are lived.

In the treatment of children, psychotic persons, and persons of extreme ignorance and naïveté, it may be necessary and desirable for the psychiatrist to include education as part of the treatment or to arrange for supplementary educative activities. These would necessarily include familiarizing the patient with the norms and expectations of those around him.

Is there basic incompatibility between belief in an afterlife and belief in fulfillment during the present?

If belief in an afterlife serves to distract attention completely from interest in, enjoyment of, and responsibility for, the present, it certainly may undermine a good life in the here and now. On the other

hand, it is well recognized that many persons who hold ardent hopes for an afterlife are living full and active contemporary lives, perhaps even risking more and striving harder for fulfillment. Various religious positions differ widely on the relative importance they place on the afterlife and on the relation of the afterlife to the present one.

Has psychiatry found scientific support for any religious concepts?

Clinical support can be found for a great many concepts taught by religion. The Bible contains a great many observations about human nature that are borne out in clinical practice. Few, if any, of these biblical correspondences have been subjected to what one would call rigorous scientific study. Nevertheless, if one examines a few instances at random, it is possible to get some idea of the frequency and simplicity of the agreements. Sibling rivalry is obvious in the Cain and Abel story, and in that of Joseph in *Genesis*. There are overtones of the force of the unconscious in undermining the day-by-day functioning of an otherwise apparently normal man—Saul. Paul's conversion gives a clue to the mechanism of reaction formation, or the sudden replacement of an impulse by its opposite tendency. The power of love to cast out fear is demonstrated in psychotherapy. The transmission of parental conflicts and guilt to children is also a familiar story in child guidance clinics. These are a scattered sampling of what may be myriads of such examples.

Is there a relationship between the paternal element in psychoanalysis and the concept of God, the Father?

The capacity of the human mind to shape others in the image of persons of importance in the individual's past is a well-known principle. It should not be surprising that we would commonly find the characteristics of a father (or of a wished-for father) projected onto God. The resultant image of God is then a personal, rather than a corporate or theological, image. Since we tend to form personal images to some extent in all our relations and eventually must find out who persons really are in themselves in contrast to our preconceptions and projections, it might well be that one of the tasks of religious education is to accept this tendency with relation to God, but gradually to guide it toward a less personalized image. Even if this happens, it seems to me that the feeling related to the father is bound to persist to some extent and that in a large measure this may indeed empower the individual to ex-

perience human feelings in relation to a Being whom theology represents as transcendent.

Is the Freudian view of sexuality compatible with Judeo-Christian standards of morality?

In many ways the Freudian view of sexuality seems likely to assist in the restoration of the authentic Judeo-Christian concept of sexuality. If the necessary reexamination of the sexual nature of man in the twentieth century leads theologians to wise and relevant judgments and applications, it may well be that the impetus of Freud will implement a return to a more realistic attitude toward sexuality. Freudian attitudes toward sexuality are commonly misperceived as implying or teaching doctrines of permissiveness, promiscuity, or noninterference. Neither Freud nor analysis teaches this. What they attack is hypocrisy, the ignoring of the basic centrality of sexuality in life at all ages, and the misinterpreting of conformity as virtue. A better knowledge of man's nature, needs, and capabilities in the sexual area may ultimately improve the possibilities for a realistic morality that is compatible with the central meaning of the Judeo-Christian tradition.

Do psychiatrists and psychologists tend, themselves, to be nonreligious? Has there been any survey that reveals this?

Psychologists and psychiatrists are not overly active as churchgoers. Among both groups are numerous persons of varying degrees of devoutness. Formerly it was not popular to raise religious issues of a personal kind within the professions, but there is a growing awareness that this issue must be examined. Some studies are already under way, although results are not available. Despite the lack of a high percentage of conventionally religious members in these professions, a latent involvement and concern about religion is evident through their growing activities toward exploring relations between their sciences and religion. The presence of more than one thousand names of psychiatrists on the rolls of the Academy of Religion and Mental Health indicates this trend. The appointment of committees on Religion and Psychiatry in the American Psychiatric Association, the American Psychological Association, and the Group for the Advancement of Psychiatry, adds further credence. Also, examination of the programs of such professional bodies indicates a growing interest in, and popularity of, studies dealing with religion.

Can the religious beliefs of the individual and of the therapist be important factors in psychiatric or psychoanalytic treatment?

The religious beliefs of the patient can be very important factors in the patient's treatment, especially if they are deeply rooted and exert a force for health, or if, on the other hand, they are tied in with neurotic problems. The therapist's beliefs as such are not dealt with in treatment. To the extent that they reinforce his identity as a helping person who respects his patient, to the extent that they are communicated indirectly as an attitude of restrained involvement, the therapist's beliefs do matter and for the good. To the extent that they leave him with prejudice or blind spots with regard to the patient or the patient's religion, they may be a hindrance. Most therapists make every effort to avoid any direct intrusion of their own religious beliefs and practices as such into the treatment of their patients.

Do religious persons begin to question their religious beliefs when they are in psychiatric or psychoanalytic treatment?

Depending upon the depth of the problem and of the treatment, and upon the depth of meaning of religion in the life of an individual patient, the examining of religious beliefs is more or less likely to occur in psychiatric or psychoanalytic treatment. Whether the beliefs as such, or the individual's motives for holding them, or the sincerity of conviction are questioned will depend on the individual's problem. It is not the analyst's task to attack or justify the belief, as such. It is his problem to allow and to facilitate conditions in which his patient can come to understand the psychological roots and connections of his attitudes toward religion. Many patients, after radically questioning their religious beliefs and attitudes, emerge stronger with regard to their faith roots, casting off previous false bases for faith. Others who discover that they believed or practiced their faith for reasons of a quite different order than they thought, may reconsider their theology or affiliation. It is possible to emerge from treatment with a strengthened old faith, with a new faith, or with an attitude of skepticism toward religion.

In what ways have Judeo-Christian beliefs influenced psychiatry?

Through the permeation of Western culture with their influence, Judeo-Christian ideas have influenced all humanistic and healing disciplines. Psychiatry has certainly not escaped. Psychiatry's concepts of

the enemy within the individual resemble the model of the medieval demons, now of course viewed as allegorical. Its holistic views of man as a unity of mind and body or of body-mind-spirit were in Judaism and Christianity first. Its concern for a morality of the heart rather than of the lips is strikingly reminiscent of the prophets and of Jesus. There are scores of other examples. The effect on Freud of his Jewish background is examined in David Bakan's *Sigmund Freud and the Jewish Mystical Tradition*, and the Christian influences on this same giant of psychiatry are delineated in Gregory Zilboorg's *Freud and Religion*.

In what ways have Eastern religions and philosophies influenced psychiatry? What are the influences of psychiatry upon existentialism? Of existentialism upon psychiatry? Of Zen Buddhism upon psychiatry?

Eastern religions and philosophies, including Zen Buddhism, have had very little obvious effect on American psychiatry. Yet a small influence has filtered in through the followers of Carl Jung, who represent a tiny minority of American psychiatrists. More recently a vogue of interest in Zen Buddhism has arisen among a more vocal but still small minority of psychiatrists who have sought to relate psychiatry more closely to some kind of philosophical foundation. Aspects of Zen have had a certain appeal, especially those connected with overcoming some of the conformity, intentionality, and utilitarianism of modern American culture.

Something of the simplicity and depth of the Eastern approaches has kindled interest and enthusiasm for assisting patients to find not only relief from symptoms, but also a way of life relatively different from the American rat race. Some of these inquirers into Eastern religions have also overlapped with a more vocal group that recently has attempted to relate existential philosophy with psychiatry, both as practiced on the Continent and in this country. Few psychiatrists would object to some of the concepts of the so-called existential psychotherapists or existential analysts, for example, the importance of allowing the patient to find his own meaning in life and of not imposing upon him the cut-and-dried categories of our science. The vocabulary and concepts of this vogue have yet to be worked out to a level of communicability that allows a general dialogue with the rest of the profession of psychiatry. Meanwhile it appears that this group has experienced the excitement of having found something new and of being in a minority. (See *Existential Therapy*)

The majority of American psychiatrists appear to have ignored or

pretended to ignore the new movement, or else have intimated that what existentialism is suggesting is already available without psychiatrists becoming involved in philosophy, an activity for which they are not really trained. The dispute is going on quietly but steadily, and constitutes an area deserving observation—one from which eventually some clarity and consensus of opinion may emerge.

Has psychiatry affected the practice of religion?

The part that psychiatry, particularly psychoanalytic psychiatry and child psychiatry, has played in shaping cultural history in the United States in the past fifty years is probably great. We must await accurate and objective historical evidence in order to ascertain its full extent. It has certainly affected philosophy, religion, and theology, both through thinkers and teachers, on the one hand, and directly through the laity and through treated persons, on the other. *God and Freud*, a book by Leonard Gross, has shown dramatically the influences of psychiatry on the practice of pastoral work in church and synagogue. (See *Pastoral Counseling*)

Are there any organizations or groups working to bring about greater understanding between religion and psychiatry?

Many local groups and several national groups are working to this end. Largest is the Academy of Religion and Mental Health, 16 East 34th Street, New York City, which has several thousand professional members in the ministry, psychiatry, the social sciences, and positions of community leadership. Others include the Society for the Scientific Study of Religion, the Religious Education Association, and the appropriate sections of the religious and professional bodies assigned to explore relations and liaison among the professions. All such organizations seem to be growing in numbers, and increasingly to appreciate the complexity of the problems. The earliest flush of premature enthusiasm has been replaced by a quiet industry in exploring and verifying, step by step and in many areas. There is promise, but work is the price of fulfillment.

RESEARCH IN MENTAL HEALTH

by MAX M. LEVIN, P.H.D.

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A reader of the literature on mental health and illness soon finds himself overwhelmed and confused. He learns that there are a tremendous number and variety of theories concerning the cause, treatment, and prevention of almost any disorder. Some investigators emphasize exclusively biological and biochemical aspects (genetic factors, metabolic disorders, abnormal substances in the urine or blood); others emphasize psychological aspects (early childhood traumata, disturbed relationships in the family); and still others emphasize sociological aspects (role conflicts, social mobility, anomie—a state characterized by disorientation and isolation—and alienation). The daily press and professional journals report the seemingly frequent enthusiastic assertions of new discoveries and new cures. Experts often appear to belong to schools or camps that differ strongly with each other. Breakthroughs in knowledge are more often anticipated than realized. In the meantime there are more speculations than facts, more myths than theories. Because of humanitarian reasons, efforts must nevertheless be made to relieve human suffering even when adequate knowledge is limited. But when practice runs ahead of knowledge, there is the danger that arrogance, dogma, and ritual may replace humility, the search for knowledge, and experimentation.

Why should we still know so little about man during this age of great scientific discovery? A good many reasons can be cited. The scientific study of man's behavior is still in its infancy. Psychology and psychiatry as scientific disciplines are less than a hundred years old. Other relevant and basic sciences—genetics, biochemistry, neurophysiology, psychoanalysis, sociology, anthropology—are also relatively young. Moreover, living organisms are fantastically complex. Methods for studying them are not readily available. Often we must wait for the application of the advances in physical sciences to biological problems before an understanding of even simple biological phenomena becomes possible. Moreover, because of the complexity of living systems the theories and methods of a number of sciences have to be integrated. Such integra-

tion sometimes requires scientists trained in several disciplines, for example, physiology and psychology, or psychiatry and biochemistry. Such persons are rare. The alternative, collaborative studies with investigators from several disciplines forming a multidisciplinary team, has become more typical. But this has attendant problems: multidisciplinary research is often expensive; and it requires investigators who understand each other's fields well enough to collaborate, and individuals who can work cooperatively.

What can be said about the substantive aspects of mental health research? What are the most active areas? What are the promising new leads? In what fields can one anticipate important new developments? What research areas are neglected? Answers to all of these questions are not readily available; some require omniscience, some require the vision of a prophet. Moreover, the bias of the writer will doubtless influence his evaluations and predictions. (Many research developments are covered in other articles in this encyclopedia.)

A measure of research activity in terms of mental health problem areas can be inferred from the distribution of research grant awards from the National Institute of Mental Health, the major source of support in the mental health sciences. For the fiscal year 1961, the number of awards in selected program areas were divided as follows:

| | Per Cent |
|----------------------|----------|
| Schizophrenia | 22 |
| Psychopharmacology | 19 |
| Mental retardation | 7 |
| Juvenile delinquency | 4 |
| Alcoholism | 3 |
| Aging | 3 |
| Drug addiction | 2 |

These grants constitute 60 per cent of the total awards made. The remaining 40 per cent probably provide support for fundamental studies in the biological, behavioral, and social sciences not immediately related to a problem area. It should not be assumed, however, that 60 per cent of the awards are for applied research and 40 per cent for basic studies. Depending on the interest and orientation of the investigator, fundamental findings are just as likely to emerge from studies utilizing as subjects schizophrenic patients or retarded children as from studies of normal subjects. On the other hand, such studies as research into mother-child relationships in monkeys or the chemistry of an ani-

mal's brain may eventually throw more light on schizophrenia or retardation than direct studies of these disorders. The arguments for or against basic research or applied research seem trivial. Given our state of knowledge, what is needed is more good research, whether it is basic or applied, clinical or experimental. All such research can lead to the new knowledge we need.

The next decade in science has already been called the age of biology. Revolutionary developments in the biological sciences seem near at hand. Significant fundamental findings in biochemistry, biochemical genetics, and physiology are unraveling the secrets of the cell. Inevitably these remarkable achievements will throw light on fundamental mechanisms related to at least various aspects of some mental disorders. Thus far the causes of some types (a small percentage, to be sure) of mental retardation are being penetrated. An inborn error of metabolism has been identified in the case of phenylketonuria (a condition that results in mental deficiency). First recognized in 1934, the biochemistry and genetics of this disorder are being clarified. Although the precise cause of the mental defect is not yet known, promising therapeutic results are being obtained by dietary limitations. Other inborn metabolic errors are now being studied and may reveal the biochemical genetic basis of still other disorders. The recently discovered chromosomal defect in mongolism, another type of mental retardation, is an additional instance of progress. (See *Childhood Emotional Disorders; Nutrition and Mental Health; Heredity and Mental Health*)

The use of psychopharmacological drugs is providing considerable impetus to biological research. A great many investigators are now studying the effects of these drugs, their side effects, and how they operate. While some have proven useful in the management of patients and in making some patients accessible to psychotherapy, just how the drugs function is by no means clear. Yet they have modified the treatment of many hospitalized patients. Hospital staff and patients have become more optimistic, more therapeutically minded. Despite increased admissions to mental hospitals, the total number of hospitalized patients is declining. An important therapeutic ingredient of drugs may well be hope. Ultimately the major contribution of psychopharmacological drugs may, however, be the extensive research stimulated by the use of these drugs. Studies in neurophysiology, brain-behavior mechanisms, methods for evaluating change in patients, even attitudes toward patients, and the complex factors enhancing or retarding the therapeutic milieu in hospitals have all had to be investigated in order to

understand more fully the usefulness of drugs. (See *Psychopharmacology; Neurology; The Nervous System and Behavior*)

Our understanding of the brain is gradually becoming clarified, although there is as yet no unified theory of how the brain functions. The contributions of chemistry, physics, and mathematics are being brought to bear in vigorous fashion by an ever increasing number of scientists. Cybernetics, computer models, and information theory are providing stimulating theoretical possibilities. Studies of brain functioning in perception, learning and conditioning, emotions, and motivation are clarifying the neural mechanisms involved in important aspects of human and animal behavior. The role of neuroendocrine functions, the functional relationship between the brain and visceral organs, and the studies of the autonomic nervous system should before too long provide information for a more complete understanding of the effects of stress and emotional states in psychosomatic and other disorders. (See *Communication and Mental Health; Perception; Learning and Reading; Emotions; Motivation; Hormones and Behavior*)

The considerable progress in our understanding of the biological substratum of behavior, and the popularity in the use of drugs may lead to an overemphasis on the biological determinants of behavior and mental illness. Such an overemphasis may represent a wish to find simplified causal explanations; or it may stem from the need to avoid the complexities and realities of psychological and sociological factors. To find the "schizococcus" and the magic drug that will provide the cure seems to be an enduring hope. However, the biochemical studies of schizophrenia, for example, are still shots in the dark. Moreover, even when the biological discoveries will come, they will need to be integrated with psychological and sociological factors. As Seymour Kety, an eminent biologically oriented investigator of mental disorders, has stated it, there may some day be a chemistry of memory but not of memories. (See *Biological Factors in Mental Illness*)

The past few decades have seen very substantial developments in the psychological and social sciences. Space permits mentioning only what appear to the writer as especially promising fields of study. The role of infantile experience has become the focus of animal and human studies. Deprivation (emotional and sensory), stressful experiences during infancy, imprinting of behavior—early "learning" during so-called critical periods—are all pointing to the relatively enduring effects of such experiences. Recently, a series of studies in several laboratories have begun to investigate the role of constitutional factors (genetic or

congenital) in response to different experiential factors. Such studies should help us understand why such traumatic incidents as, for example, prolonged separation of an infant from its mother, should have more disturbing effects on some infants than on others. (See *Sensory Isolation; Constitutional Variation and Mental Health*)

The field of psychosocial development is now attracting a substantial group of behavioral and social scientists. More penetrating studies of the socialization of the child, the role of different child rearing practices, and the impact of varying family atmospheres are subjecting some of the cherished beliefs about childhood and child rearing to scientific testing. Investigators are now beginning to study the important years of late adolescence and young adulthood. The formation of ego identity is stimulating new studies of the problems of youth in the contemporary world. A full understanding of development will also require study of later stages in life. These, too, are now receiving more intensive study. (See *Parenthood and Child Rearing; Child Development; Adolescence; Young Adulthood*)

In the social sciences—social psychology, sociology, anthropology—understanding of the functioning of small and large social groups is increasing. Studies in social perception, interpersonal relations, the effects of groups upon individual behavior, research on authoritarianism, and conformity pressures are clarifying the role of social variables in attitudes and behavior. Studies in social class and mental disorders have indicated the existence of differential rates in the various kinds of mental disorders treated in different social classes. Moreover, they have provided evidence that treatment is likely to be quite different depending on whether a patient belongs to a so-called upper or lower social class. (See *Social Factors in Mental Illness; Social Psychology; Social Anthropology and Mental Health; Culture and Personality; Social Status and Mental Health*)

Sociological studies of the mental hospital as a social system or community have shown the influence of subtle interpersonal relationships between staff members and patients, even the effects of the interpersonal relationships within the staff, on the symptoms of patients. We are beginning to learn much more about what is significant, with the result that the mental hospital can become more than a custodial institution and can become a truly therapeutic community. (See *The Therapeutic Community*)

A number of behavioral scientists have begun to focus their attention on the study of mentally healthy—or at least effective—individuals and

families. Early findings suggest that such persons are not free from problems and conflicts, but are able somehow to cope effectively with them and even convert them into sources of strength, at times even into creativity. Further studies will need to reveal the details of personality and family characteristics that combine to make effective coping possible. Additionally, the social influences and social institutional supports related to the achievement of mental health need special study. More penetrating study of the roles of education, work, play, and recreation in the psychological economy of individuals could enlighten us about how to achieve and maintain mental health and perhaps even about how to prevent some mental disorders. (See *Play, Recreation, and Mental Health; Creativity; The Family in Illness and Health; Personality*)

More strictly, clinical research—outside the area of psychopharmacology—is not developing as vigorously as might be expected. Clinical investigation is by its nature more complex and requires sophistication in both clinical procedures and research methods. Methods for studying such complex phenomena as psychotherapy or psychoanalysis need to be developed further. Methods for the evaluation of outcome of such treatment procedures are still inadequate. We need much clearer and acceptable criteria of cure or even of recovery. Moreover, we need more accurate methods for assessing changes presumed to be significant. But even less complex clinical problems have not been sufficiently explored. Careful studies of the natural history of most disorders—their onset, their course, “spontaneous” changes—are, in the main, still lacking. Clinical research will become even more essential as fundamental research and laboratory findings accumulate, inasmuch as it will become even more important then to evaluate clinically the causes and cures suggested by basic research. (See *Psychotherapy; Group Psychotherapy; Psychoanalysis; Psychology*)

In the face of the great need for research, what is the history and extent of available support? Aid for research in mental health is a relatively recent development. Before World War II, a few of the large private foundations provided limited although very important funds. Then, as now, most support of health research was devoted to physical health problems. Because of the limited interest in mental health nationally, foundations (Commonwealth, Rockefeller, Russell Sage, etc.) often supplied essential funds for the training of mental health personnel to render services and for the establishment of mental hygiene clinics. A limited number of financial awards were made available to

leading scientists in fields closely related to mental health. Universities, of course, also provided time, space, and limited research funds to faculty members for their studies. A few states had established psychiatric research institutes with a limited number of research positions.

The passage of the National Mental Health Act in 1946 marked a turning point. The establishment of the National Institute of Mental Health not only attested to the national recognition of the mental health problem but also made clear that the federal government was ready to undertake and support more extensive research than had heretofore been possible. Beginning slowly with only \$373,226 for research grants-in-aid and research training in the fiscal year of 1948, these funds have steadily increased so that by the fiscal year 1961, a total of \$34,235,000 had become available. Despite this great increase, support is not yet adequate. As William Soskin pointed out, for the year 1958 approximately \$70,000,000 was available from all sources, an amount that is approximately the cost of constructing and firing two Atlas missiles. To be sure, state governments are slowly beginning to increase their contributions to research in mental health by establishing additional research positions and providing research grants-in-aid. Several foundations (the Foundations' Fund for Research in Psychiatry in New Haven, the Hogg Foundation for Mental Health in Austin, Texas, and a number of family foundations) are devoting all or much of their funds to mental health research. The National Association for Mental Health has also begun to provide research grants-in-aid. However, private foundations are playing a relatively minor role in providing support. The best and most recent estimate of support available from all private foundations is about \$4,000,000 during 1958. It is not surprising, therefore, that the first recommendation of the final report of the Joint Commission on Mental Illness and Health, established by Congress in 1955, dealt with the pursuit of new knowledge and included a recommendation for extensions and expansions in the research grant program of the National Institute of Mental Health as well as the programs of state governments. (See *The National Institute of Mental Health; National Association for Mental Health*)

But money alone—even in increasing amounts—will not provide the answers. Nature will not be bribed into revealing her secrets; knowledge cannot be bought. Many observers of the research scene in the mental health sciences would agree that currently the single greatest obstacle is the absence of an adequate number of able investigators, with the greatest lack in the field of psychiatry itself. It has been

estimated that 90 per cent of the research grants-in-aid from the National Institute of Mental Health are awarded to physiologists, pharmacologists, psychologists, and social scientists, with 50 per cent going to psychologists. It could be argued that this is as it should be. These are the relevant mental health sciences. The clinicians must devote all of their energies to treatment of the present generation of the sick and suffering. Understandable as this argument may be, progress in the other health sciences has required the active research endeavors of clinicians. There are no *a priori* reasons to assume that this is not the case in the field of mental health. Fortunately, progress is now discernible. Increasing funds have become available to improve research training in psychiatry. Psychiatrists interested in research have found support in such grant programs as the National Institute of Mental Health's Career Investigator Awards for young research psychiatrists, the fellowship program of the Foundations' Fund for Research in Psychiatry, and the American Fund for Psychiatry. Funds for teachers of research have also been available from the National Institute of Mental Health and the Foundations' Fund for Research in Psychiatry. In addition, an increasing number of more secure positions are becoming available to psychiatric investigators. The Foundations' Fund for Research in Psychiatry has recently endowed four research professorships in departments of psychiatry in medical schools. The National Institute of Mental Health has inaugurated a Career Development Award program, which includes long-term support for senior investigators. Increasing numbers of research positions are being established in state mental hospitals. (See *Psychiatry; Careers in Mental Health*)

It should be emphasized that even with great encouragement and support rapid progress should not be anticipated. Crash programs are not likely to yield fundamental discoveries in areas where we are still uncertain about what to look for and about what is likely to be found. Accumulation of basic knowledge is typically a gradual, cumulative process even though marked by brilliant insights and discoveries. For example, it took a half century of intensive work to make possible the development of the Jonas Salk vaccine.

There is some danger that slow progress can result in pessimism and discouragement; men of action can become understandably impatient. But even more serious may be the opposition to the scientific study of man that arises from other sources. Some persons fear what man may learn about himself and what the implications of such findings might be—either philosophical or even sociopolitical. Some mis-

takenly fear that the scientific approach is cold, detached, and mechanistic and leaves no room for humanistic understanding and sympathy. Opposition of other persons stems from a more pervasive anti-intellectualism. The history of knowledge, however, indicates no better method of arriving at tested knowledge than the method of science. A genuinely scientific attitude is free from dogma, and encourages creative thinking and experimentation. Moreover, the search for understanding should include the avoidance of blaming. The more we learn about the troubles man has to put up with in illness and in health, the greater our compassion and humanism will be. (See *Mental Health; Optimum Mental Health*)

RESIDENTIAL TREATMENT FOR EMOTIONALLY DISTURBED CHILDREN

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What is meant by "residential"?

The term "residential" has been primarily selected in order to avoid the flavor of mass herding, custodial storage, or lack of therapeutic implementation which the older term, "children's institution," seems to convey. On the other hand, it is meant to differentiate its type of treatment from other therapies offered in social agencies, child guidance clinics, outpatient departments, etc., by the simple statement that the children "live" there. In short, a residential center is expected to provide a full range "living-in" situation, rich in personnel and equipment that child life normally would need, catering to all the growth needs of children, including those that are not directly related to the specific emotional disturbance for which they are sent to it.

What makes it a "treatment center"?

In contrast to the better known design of an orphanage or a "children's institution," which cares for children without families—or with families from whose influence they had better be removed—the residential treatment center undertakes a very specific task, over and beyond the provision of total life needs, as the term "residential" implies. The idea is that specific disturbances of the children referred have been well diagnosed, are clearly enough marked to indicate development of a clear-cut treatment plan, and that the center is equipped to offer the specific types of treatment or a combination of them that a child needs in order to recover from the ailments which beset him.

Thus, the child's stay in the treatment center is decided upon, not only because he needs a good place in which to grow up, but because some very specific therapeutic measures are to be taken, a very clear-cut "repair job" has to be done. While it is hoped that the whole environment in the center is in a way "good for him," the real criterion,

that makes a place a treatment center, is the carrying out of a very specific therapeutic plan.

"Treatment of what?"

Rather than pretend to be able to be "all things to all men," treatment centers usually try to cater to a specific type of disturbance, or at least to a somewhat definable range of disturbances, even though individual children may still vary by mixture or degree. This is even more necessary for residential centers than for outpatient or consultation clinics. These children do not only come there to meet their therapists—they also have to live with each other. While it is true that children with a variety of difficulties may often be well taken care of in the same school or institution, the possibility of catering to varying treatment needs in one and the same place is limited. Very clear-cut demarcation lines as to which disturbances can be treated together with which other diseases, in one and the same center, do not as yet exist. However, most centers develop on an empirical basis a practically adequate guideline that helps them decide which range of emotional problems they can most fruitfully encompass. Thus, some centers focus primarily on the treatment of outright cases of schizophrenia, others consider themselves quite well equipped to give help to certain types of neurotic children, while still others are expected to deal with action-prone "character disturbances." Some are flexible and large enough to combine clusters of any one of these. However, most children would not fit specifically into any one of these categories. Rather, they accumulate a wide assortment of problems that defy clear-cut categorization. Residential treatment centers are accustomed to that complicating factor, and realize that they have to provide a wide range of life experiences as well as therapeutic designs. Thus, for instance, a child may be referred because of his indomitable upsurge of disorganized aggression, which is worse than any regular home or school could possibly cope with. At the same time, he may also have developed some rather obviously "neurotic" reading disturbances or learning blocks. In that case the treatment center can take him on only if it is also able to provide for him good home care and an adequate activity program for most of the day and night, a psychotherapist who takes him into "individual treatment," special therapy on reading disturbances, and a flexible enough school program.

In other cases, children may be in well enough condition to make use of a regular school situation in a clinically sophisticated public

school of the center's neighborhood, but may be in need of therapeutically designed handling for the rest of their waking hours, and also of a therapist who is available at any time during the day or night at the onset of such a child's temper outburst.

Thus, the "residential treatment center" has to take care of all growth needs of the children, it has to provide specific forms of treatment for the major disturbances it takes on, and is sometimes able to utilize outside agencies for some of these treatment needs that fall beyond the major emphasis of the original design of the center.

Theoretically there is no limit to the combination of disturbances that may need therapeutic implementation. In practice, at the present stage, residential treatment centers show a heavy concentration on those emotional disturbances that are accompanied by uncontrolled, disorganized, aggressive, and destructive behavior, on the one hand, or on anxiety states, fears, or emotional blocks of such intensity that they make a child's functioning in any other setting impossible.

No matter what the main line of a child's emotional disturbance is, however, most children referred to residential treatment centers usually also show symptoms such as bed-wetting, temper tantrums, nightmares, destructive or suicidal fantasies, "psychotic-like episodes" in spite of good basic capacities for learning and adjustment, extreme forms of restlessness, special learning blocks, inability to make positive relationships even to friendly adults, difficulty to accept their place in a group of other children, extreme forms of fear under situations of competition, not to mention the wide range of so-called "psychosomatic" ills—that is, diseases that look very much like their medical counterpart, but are primarily based on psychological factors, with body functions basically well intact.

Over and beyond that, we also find many residential treatment centers quite capable of incorporating into their primarily emotional disturbance-oriented program, children with specific physical handicaps, especially if some of their emotional disturbances have developed on the basis of such handicaps.

What do we mean by "treatment"?

The experiences to which the child is exposed and which are considered instrumental in his recovery have a wide range. On the one hand, there are all the "special therapies" that are also found in outpatient clinics, hospitals, and institutions in general: psychiatric treatment (with or without the inclusion of medication or drug therapy),

individual psychotherapy, group therapy (of the discussion group or activity group therapy style), occupational therapy, special arrangement for the treatment of reading and speech disorders, etc. On the other hand, there are all the possibilities for treatment which the fact of "living-in" provides: close supervision by well-trained adults, exposure to benign handling, even in moments of behavioral upset, by counselors, teachers, and recreation leaders, who all collaborate with the doctors and psychiatrists on the overall treatment job.

There is the benefit of a well modulated and carefully planned life routine, activity programs, supervised by a staff who are trained to adapt whatever the situation or activity calls for, to the specific needs and shortcomings of the children, and who are also skilled in helping children "manage" life situations and play or learning experiences which they would not be able to "take" without great confusion or emotional blowup if encountered in regular school or in the open community. Since school and learning is for a child what "work" and a "job" means for an adult, all residential centers are faced with the need of providing for their children a proper school and learning experience. They may do so by utilizing outside facilities, or by developing their own, made to measure for the needs and readinesses of their child patients. This, by the way, does not only mean special remedial education in those areas where the emotionally disturbed child is by now deficient; it also means the provision of healthy and stimulating learning experiences for those who are quite capable of such, but could not partake because of the nature of the rest of their illness. In short, the child who has become dull and "learning-hostile" as part of his emotional problem may need special educational provisions made for him. Equally though, the child who is brilliant and way ahead of himself in intellectual capacity, but is unable to work in groups because of his anxiety state or his intermittent outbursts of unmanageable wrath, needs a well-thought-out schooling design to meet his requirements.

Frankly, at this moment in the development of residential treatment centers, the variety is so great that it defies description under the heading of a short formula. Also, most treatment centers differ in the emphasis they themselves put on certain phases of their therapeutic work. Thus, you will find that some pride themselves on the psychiatric therapy they make available for their children, and consider it the major "treatment force," while they would still take for granted the need for good remedial reading for some of their children. Others may "take for granted" that the child needs some such psychiatric therapy,

but they would argue that this treatment could also be obtained for the child in a clinic in the open community. What is so special about the residential treatment center, they propose, is that the youngster can have excellent care, proper schooling, appropriate adult supervision, skillful handling of all his predicaments, and a warm and tolerant but not overpunitive nor overpermissive atmosphere to live in. In fact, many centers would argue that the very combination of therapeutic methods listed above is the unique feature of their services, and would hesitate to list any one therapeutic provision, such as "individual therapy" or "work on reading disturbance" or "clinically skillful mothering" as their main therapeutic force.

Research on the specific way in which any of these factors may work together, and which combinations are needed, in what degree, and for which type of "disturbance clusters," is still in the early stages of development.

Who really does the "treating" of the child?

The types of people a residential treatment center needs to do its job range all the way from staff that is usually found in any good child care institution, to special services one would otherwise expect to find mainly in a good clinic or psychiatric hospital. There is also a need for staff that is responsible for the schooling of the children and for their recreational life.

Thus, you may find psychiatrists, psychiatric social workers, and others doing a "casework job," along with social group workers, recreation leaders, and "houseparents." You may find "counselors"—the word being used here in the meaning it has assumed in American camping—teachers, speech and reading therapists. You may find psychologists involved in the testing and diagnostic work-up of the children, but also heavily engaged in actual psychotherapy, individually or in groups, usually under the supervision of a psychiatrist. It has frequently been stressed that in the treatment of severely disturbed children not only are the house and direct treatment staff of importance, but any person with whom the children come in contact may have an important impact on overall success or failure of therapy. Therefore, people in the roles of cook, janitor, and maintenance personnel are also sometimes considered part of the "professional staff," even though such implications may not extend to their official job classifications. They are, of course, in those cases, involved much more in staff discussions, in training about

child handling, and in overall professional concerns than would be traditionally the case.

If the residential treatment center is part of a hospital, then the staffing would, of course, extend to the usual hospital staff classifications, such as psychiatric nurses, nurses, attendants, occupational therapists, etc., even though the actual roles these people assume in the children's lives would be quite similar to those in the nonhospital centers.

The degree to which a given residential center uses any one of the professions mentioned above, and the proportion in which they are involved, will vary depending on the specific design of the center, its administrative structure, its overall treatment philosophy and, of course, its scope and size. One must, therefore, not be surprised if one center may put heavy emphasis on having its psychiatrist full time, supported by several therapists under his supervision, trained in the discipline of psychology, psychiatric social work, nursing, etc., and although they consider the rest of the house staff important, these are not actually part of the therapeutic team. Another center may well put its major emphasis on the handling of children received from those with whom they spend most of the time—houseparents, counselors, teachers, group workers, recreation leaders, etc.—but acquire special, psychiatric, and other more specified therapeutic services on a part-time basis. In all cases the children are, of course, under well-established pediatric supervision. There are social caseworkers involved, who provide the necessary "case history" on children before admission, who are busy helping the family of the child support the treatment of the residential center, and who prepare them hopefully for the child's more auspicious return, or who make plans for future placement of a child if the return to his own family should be deemed unfeasible, when intermediate steps seem to be preferable. In some centers the original referring agency carries most of that load; in others, a special intake and placement department is part of the center's staff.

How does one find a residential treatment center, and how does one go about placing a child?

From what has been said previously it would hardly be surprising if we followed our description with the statement that residential child therapy is, of course, very costly indeed, and at this stage of development cannot be provided cheaply. Beside the complexity of facilities, services, and staff to be provided and the professions to be involved, such centers obviously cannot become too large; and even where larger

numbers of children are served, they have to live in small subgroups and need a great amount of highly individualized service. Thus, the actual cost of running such a center goes way above what it costs to keep a child in a good children's hospital, though in actual sums of money this varies, of course, with the intensity and complexity of the services offered. Because of this, most such centers have emerged where public funds furnished the basis for their development, or as experimental branches of larger already established mental health services, or as small, privately financed nonprofit projects, supported by special donations or foundation money. In many cases the development of such centers has also been tied to the proximity of a university for training and research, and through it offer excellent but less costly staffing, since students and residents on all levels would be accustomed to work for lower salaries, considering their reward part of their benefit in training, academic credit, and professional preparation and prestige. Under these conditions it is also possible to acquire highly specialized services of people who are already employed by the local university, the school system, or hospital, as well as a research institution, on a part-time basis, rather than load a small and highly specialized operation with the financial burden of full-time employment of so many specialists in so many fields.

Unfortunately, exact figures of the cost of residential treatment are at this time not available, since they vary so much depending on locality, size, and scope of the project, combination of special treatments involved, and the degree of support of a given institution through public, private, or foundation funds. A figure of \$5,000 to \$8,000 per pupil per year, often not including highly specialized additions such as more frequent psychiatric therapy sessions, etc., seems to be a realistic estimate. Fortunately, some centers have special funds that allow them to reduce the charges to the patients, and in some publicly financed institutions there is only a slight charge, while others are free. Unfortunately, those are few and the number of children they can take is usually limited to a very small group at a given time. Where they are publicly financed the additional problem is that they are usually under pressure to serve as many children as possible, in order to bring the "per capita costs" down, which then means they either have to become larger than is good for them, or are forced to limit their excellent and intensive services to a few months' time, so as to have "bed space" available for those on the waiting list. This is unfortunate because, of

all therapies, residential treatment is unpredictable in its duration and its success is especially endangered by premature interruption.

A few publications list existing residential treatment centers, but unfortunately none of these is either totally up-to-date or complete, and with the complexity of the issues described above, it is not surprising that each publication uses its own standards for the decision of just what should or should not be included under the term "residential treatment center."

A better approach for information would be to apply to any one of the local resources, such as child guidance clinics, family service associations, outpatient clinics, or any other of the local professional organizations that customarily deal with the problems of children. Where finances are not the issue, private psychiatrists who deal primarily with children and adolescents are usually well informed about types of service available and how to go about choosing the right one, or finding one that can take the child.

How do we know whether "residential treatment" is what a child needs?

In general the older the child the more difficult it is to find a proper residential treatment center for him. Few of them are designed for the adolescent, and other things being equal, it is less difficult to find services for a school-age child below twelve years than for one in the teen-age years.

The recognition of the special value of residential therapy for a variety of childhood disturbances is a relatively recent development. Like all new discoveries and promising inventions, residential treatment also suffers from the phenomenon of "novelty shock." By this we mean that the general public has a tendency either to underestimate or overestimate a residential center's performance. It is unfortunate that communities often shy away from developing residential centers because of their cost, even though it is by now quite clear that certain types of disorganization of the mind do not respond to anything short of such a complex and completely encompassing approach. With the emergence of a residential center a trend has arisen to place any child with problems in such a center, so that the unmanageability of a child is automatically considered a criterion for his placement in a residential treatment center, or that regular child care institutions and children's homes are deemed "no good" unless they are called residential treatment centers.

This is unfortunate, and one ought to stress (1) that many children

with problems—even with problems of “acting out”—can be treated within the usual framework of family counseling, of a child guidance clinic, or of outpatient clinic services already in existence; (2) many severe behavior and learning problems that now seem unmanageable outside an institutional setting, do not necessarily need a “residential center,” but are in need of very specialized, small, and well-staffed “special classes” for emotionally disturbed children, possibly with additional placement in group therapy of an outpatient type, and individual clinic-psychotherapy or a combination. The cry for “residential treatment centers,” with the subsequent disappointment on the basis of cost, is all too often made a substitute for adequate services on other levels; (3) a treatment center is in itself not “better” than other institutions, such as children’s villages, children’s homes, boarding homes, and children’s institutions, including some for delinquents. It is not the title of “treatment” nor the adjective “residential” that makes the difference. Some institutions are incredibly bad, some are excellent. Likewise, a residential center may be good or bad, depending on how it is run, staffed, and financed. The question is not that of a choice between “good” or “bad” residential care, but of the assessment of the specific treatment needs of a given child. Some children need the specific climate and program of a good boarding school, a children’s home, or children’s institution. If that is what they need, it is the perfect answer for them, and some marginal special services can frequently be offered in addition to such institutional care, by a special staff, such as caseworkers, special teachers, etc. For such children, a residential treatment center is not needed, even though they may be difficult and hard to handle at the time of admission. Other children need a better designed place in which to live while an outpatient clinic or social agency works with them, and in those cases a combination of placement in a good children’s home coupled with some psychiatric casework or special therapy by a community clinic or agency, or from private sources, will do the trick.

The special recommendation of a “residential treatment center” should be limited to those children who need the specific combination of all the above mentioned services under one roof and in close proximity to each other. On the other hand, if this is what a given child needs for his recovery, it must be said quite frankly, then nothing else will do. This ought to make it clear that the decision in favor of “residential treatment” is one which the parent would hardly be able to make wisely without consulting specialists who have experience in ex-

actly this type of assessment. Most treatment centers, by the way, will require such preadmission diagnosis before taking a child, or they are equipped with their own staff to do the diagnosis themselves.

What can we do about the "waiting list"?

The creation of enough high level residential treatment centers on a more reachable cost basis and with adequate spread over age ranges is a task for community planning at large, and should be the obligation of all public-minded citizens, just as other public and private services for the care of general health. At this time, while the concept of the residential treatment center, its therapeutic potentials and limitations has become an issue of generally recognized urgency, the amount of actual services of this type available is totally inadequate. Money is not the only block. Even the very rich will find it hard to locate a residential treatment center for their children because most of them are filled to capacity and have a long waiting list, and if the child is closer to teen-age or if his disturbance happens to be accompanied by a heavier dose of aggressive or destructive behavior, the facilities you look for are hardly even on the map. Steps in the right direction could be listed in the following sequence:

- 1) Creation of adequate numbers of services for the preresidential treatment needs. For instance, if a community would have really sufficient well-designed foster home services for children whose homes are broken up, plus really adequate classes for children with early behavior problems in schools, plus casework or outpatient services with small enough case loads to combine such resources for children who need them, the number of children who would later need residential therapy would go way down.

- 2) Therapeutic implementation of other institutional or school services. There is something between a residential treatment center and a good regular children's institution or type of boarding school. Many children need an institution or boarding school type placement that can deal with their living and behavioral needs. There are some available. However, they also need simultaneously some more intensive psychiatric or casework treatment, remedial reading, or speech therapy, or the like, but these services are not available in the community or to the institution or school which otherwise can well take care of the living needs of the child. The more frequent combination of "outpatient type of treatment" for children who happen to live in an institution or school that can manage them would cut down on the numbers

of children who are now flooding the intake gates of residential treatment centers.

3) The creation of adequate foster homes, boarding homes, and child care services that can deal with the "acting-out child." The reverse of the above point also needs to be made. Sometimes the clinic or consultation or other treatment services of a community can well take care of the child's problem, provided they could find somebody who could live with the child and bear up under his behavioral tantrums while the child receives the treatment available for him. The children's home, boarding schools, recreational facilities, etc., in the community are not equipped or not well enough staffed to encompass more "difficult" behavior clientele. Thus, with better facilities for wise and skillful handling of the very hard-to-take child behavior, which are available in the community at large, the existing clinical facilities could reach children who otherwise need to be referred to residential treatment centers simply because nobody wants to live with them while they receive the treatment they need.

4) Last, there is no substitute for the creation of more residential treatment centers for a wider age and disturbance type. While it is possible to hold off the waiting list customers who really don't need what they are searching for—they only searched for it because they didn't find what they really needed—there will always be enough of them who really need the specific combination of services found in a residential treatment home. Needless to say, one of the biggest blocks to adequate servicing of child treatment needs, that clogs up all our community services, would then be overcome in the residential treatment field. Above all, services must be made available irrespective of nationality, religious affiliation, race, or financial means of those afflicted by a type of disturbance for which this service is the best answer we know at this time.

What are the "results" of treatment in residential centers?

The "follow-up study" of any type of treatment is an extremely complicated affair. The greatest problem where children are concerned lies in three handicaps under which the follow-up researcher invariably labors:

1) Children are growing organisms, and each developmental phase may produce problems in its own right, no matter how well the previous phases have been "gone through." For the researcher who hopes to assess the effectiveness of treatment this constitutes a great difficulty.

Let us look at the most normal children. Aren't some of them wonderful until they hit the "teen-age," at which time some rather unexpected complications or outright "symptoms" may appear? How do we know which of these are "illnesses that beset them now" or are the fault of "older problems not well taken care of"? Thus, the child leaving the residential center in reasonably good shape at the age of twelve may very well suffer renewed complications at the onset of adolescence. Who is to say this could have been avoided, no matter how well he had his original problem cleared up by his stay at the residence? Yet would such a case be counted a success or a failure?

2) In physical diseases the general public has become quite realistic as to what a good doctor or hospital is expected to do. The fact that the pneumonia of yesterday is cleared up successfully does not mean the patient cannot contract it again. In the field of all psychological and psychiatric illnesses, the general public's expectations are not as realistically focused. Thus, discharge from a residential treatment center after successfully coping with a specific behavior or learning problem, or an acute neurotic or psychotic state, is frequently expected to guarantee also the full rebuilding of the character, talent, and abilities of the child patient, and that it should last for good, no matter what people do to the child afterward. Thus, any reoccurrence of a problem is generally considered a lack of success, even though this problem may be not a repetition, but an entirely new event—just as the child can get pneumonia again, or break his other leg at a subsequent skiing party.

3) To follow the children who have been treated in residential centers with any expectation of adequate research design would mean to inspect the total life experience of their future years as thoroughly and in as much detail as was known and recorded during their stay at the center. Such totality of data collecting is extremely difficult, rare, and hard to get, with the result that most purely "statistical" accounts of successes and failures remain rather meaningless, whether they are positive or negative. Complex and long-range studies of all the relevant factors involved have not yet been undertaken.

On the other hand, in spite of the disappointment which the above points must mean for our hopes of finding "clear-cut follow-up answers," there is enough evidence in clinical literature to ensure the value of the residential treatment design as a valid treatment instrument in its own right and beyond doubt. While believers may be inclined to chalk up too much later success in individual cases to the job their special

pet practice performed, critics have a knack to discard any success, claiming that it would have happened anyway. There is enough evidence available of cases where it is quite clear that "it would not have happened anyway," just as with other therapies, and cases where the actual success reached during residential therapy is quite clearly definable, even though later complications did set in independently. Especially with forms of emotional disturbance that have a heavy admixture of aggressive and destructive action beyond the usual behavioral tolerance of any more traditional child care or therapy agency, the unique chances of a total residential design compared with any other single treatment operation, no matter how excellently performed, are widely recognized by now. After years of doubt, for instance, the most general present complaint of referring psychiatrists is not their question about therapeutic potential, but rather about the unavailability of enough residential treatment facilities for children who need them most.

Just as in other therapies, success or failure is dependent on the cooperation of other people involved in the child's life, and in the case of children without families, it is especially dependent upon the degree to which the referring agency is capable of implementing the needs of the child after discharge.

SCHIZOPHRENIA

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What is the extent of the problem of schizophrenia?

It has been estimated that about one half the hospital beds for the mentally ill are occupied by patients who have schizophrenia. This proportion continues despite improved methods of diagnosis and treatment. Moreover, for each institutionalized schizophrenic patient, there are several others in the community who either have not been diagnosed or have been discharged as cured or improved. Plainly, the illness now known as schizophrenia is a major problem of mental health today.

Is schizophrenia a single illness?

This question can best be answered by reviewing the historical development of scientific concern with mental illness. During the Middle Ages, persons who showed unusual, bizarre, or incomprehensible behavior, either in words or actions, were considered "possessed" by evil spirits, the devil, or some other supernatural force. Unable to understand such behavior, the average individual felt frightened and stayed away from the afflicted, and society in general insisted upon their isolation. Historical examples are certain aspects of the Inquisition and the burning of witches. Around the time of the French revolution, with the advent of scientific medicine based upon knowledge gained from the natural sciences, physicians began to deal methodically with abnormal mental behavior. Using careful observation, they classified the illnesses into groups according to the patients' prevailing symptoms, from which the various names were usually derived, e.g.,

catatonia, in which the patients' bizarre physical posture is highly impressive, was considered a specific disease.

The next step, the search for causes, was principally conducted in large state institutions, with their array of patients whose behavior had become so unacceptable that they could no longer function in organized society, or who presented problems in management and were dangers to themselves or others. Investigators now began to scrutinize the course that the illness took. Some illnesses had a remitting (come and go) character; and it was particularly important that between attacks the patient was able to maintain a level of relatively normal appearance and functioning. Another group of diseases had a slow, insidious onset and tended to be progressive in character, down to the point of ultimate mental deterioration. To this second large category of progressive and deteriorating type of illness was given the name of *dementia praecox*.

A third approach was the search for tissue changes within the brain. Illnesses like syphilis of the brain could be associated with distinct patterns of a change in behavior, although it remained a moot question why such patients differed in their symptoms—some became depressed, others were elated. Yet for *dementia praecox* no such germ-induced tissue changes could be demonstrated.

Whenever medical investigators cannot arrive at distinct causes, they review the concept of an illness. Such reformulations usually occur on the strength of the review of symptoms and the course of the illness. Conceptualization of illnesses means bringing a variety of disease pictures under a general pattern. Swiss psychiatrist Eugen Bleuler observed in patients with *dementia praecox* bizarre behavior and a peculiar form of thinking and feeling. Nor did patients with such disorders of feeling and thinking universally succumb to the full consequence of *dementia praecox*. He therefore elaborated some primary symptoms to be found in many persons with this illness, regardless of the outcome. He considered the fundamental symptoms as disturbances of affect (feeling tone), of association (the connection of thought patterns), of ambivalence (the coexistence of contradictory thoughts and emotions), and of autism (a form of feeling and thinking wherein the patient reacts more in terms of his own inner reality and his accumulated life experiences, than of the demands of a conventionally accepted outer reality). Presumably the more dramatic and bizarre symptoms were actually accessory symptoms or elaborations upon the patient's disordered feeling and thinking, as expressed in the funda-

mental symptoms. Finally, Bleuler conceptualized the illness in terms of the predominant fundamental and accessory symptoms and on the basis of the age of onset rather than on the terminal course or outcome. Undue emphasis on the ultimate deterioration left out the many disease pictures that had the principal earmarks of a disorder of thoughts and feelings but never progressed to a grossly demented stage.

From this emphasis on the fundamental symptoms, Bleuler called the disturbance a "splitting" (schizophrenia derived from the Greek words for split—*schizo*, and mind or mentation—*phren*) of the principal mental functions (perception, emotionality, and intellectual functioning), which therefore lay, so to speak, side by side within the individual and could neither be integrated by the patient nor comprehended by the normally adjusted observer; hence the term "schizophrenia."

Bleuler spoke of schizophrenias, never considering schizophrenia to be a single illness, but rather a series of related patterns of reaction to unknown causes or stresses. He always believed that ultimately physical causes within the central nervous system could be found to explain the patient's reactions.

How did the name "schizophrenia" originate?

In 1911, Bleuler, in interpreting the symptoms of dementia praecox, noted that patients with dementia praecox showed a peculiar "splitting of the mental functions," particularly a discrepancy between expression of feeling, tone (the affect) and the content of thoughts. For instance, a patient with grandiose delusions of being a powerful and important individual might rather casually and without protest accept a subordinate role in life. Another might burst into uncontrollable laughter at the death of a beloved relative, whereas a third might appear detached and uninterested in the face of an actual need for self-assertion or success.

What forms of schizophrenia did Bleuler recognize?

Bleuler recognized the *simple* form of schizophrenia in which the splitting of mental functions was not elaborated by accessory symptoms. In such patients, usually a rather nondramatic course of illness ended in gradual and moderate decline of social functioning, with some degree of withdrawal and isolation. A second group was named the *hebephrenic* type of schizophrenia (*hebes*—youth, and, therefore, hebephrenic denotes a mode of thinking, feeling, and behavior inappropriate to one's maturity). Patients with such reaction patterns had

previously been operating on a higher level of achievement and gradually conveyed the impression of a "burned out, hollow shell," with silly, inappropriate, and infantile manners that yet retained the earmarks of a preceding disturbance of schizophrenic character. This type of schizophrenic illness constituted an end state and a more unfavorable outcome. The next group was characterized by accessory symptoms of bodily behavior, excitement or stupor, and bizarre muscular activity. Such postural oddities were at first thought to be related to nerve cell damage in the spinal column or to the tonus of muscles, but this proved erroneous. The term "catatonia" (*kata-tonos*—downward tone or decreased tonus) was applied for this set of symptoms. Bleuler connected his postulates of fundamental symptoms with the accessory states of disturbed body function and spoke of a *catatonic reaction* form of schizophrenia. Finally, he aligned another form of known mental illness, "dementia paranoides," with his ideas about the primary disorder in schizophrenia; in the *paranoid* form of schizophrenia the patients' physical and general intellectual behavior seemed unimpaired, yet they exhibited peculiar beliefs (delusions of persecution, etc.) in an often limited field of their existence, thought, or behavior.

What conclusions can one draw from this grouping of the schizophrenic illnesses?

One can draw the following conclusions:

- a) The simple type of schizophrenia is likely to be chronic in character and course, but patients given somewhat sheltered surroundings often need not enter hospitals.
- b) The hebephrenic type of schizophrenic illness must be considered the most unfavorable outcome of schizophrenic reactions. Its course tends to be progressive and seldom leads to a spontaneous remission or arrest.
- c) The catatonic forms can be observed as isolated, acute episodes. A patient may have one attack of catatonic excitement or stupor, for which he is hospitalized, recover with or without much medical help, and never experience a similar illness again.
- d) The paranoid forms occur to varying extent and degree. The patients do not always need to be hospitalized nor are they necessarily completely socially ineffective.

These classical and distinctive types are rarely seen in pure form. During the course of schizophrenic illness, one variety may prevail,

then be superseded by manifestations of any of the other types. In such cases, we therefore often speak of mixed or undifferentiated types of schizophrenia.

Of what advantage is the consideration of symptoms in any disease?

The assessment of symptoms allows the physician to prognosticate the course of a given illness on the strength of his acquaintance with a multitude of similar cases. Therefore, such subdivision has served well to predict the patient's fate. However, as in any other medical illness, such predictions amount to an educated guess and should never be considered infallible.

Has the concept of schizophrenia undergone revision since the work of Emil Kraepelin and Eugen Bleuler?

Although symptoms and types have perhaps been most comprehensively described by these authors, speculation about causes continues. In general, these speculations concern areas of conflict between a growing individual and his surrounding world as causal or contributing factors to the illness, and the investigation of organic determinants.

a) *The psychoanalytic concept:* Ever since Sigmund Freud in 1911 began to speculate about the meaning of the schizophrenic's symptoms in relationship to a person's drives, attention has been paid to peculiar forms of relationships during childhood. It is now believed that if a child during his earliest phases of development (six to twelve months), before he has attained full mastery of speech, is confronted with overwhelming interpersonal stress beyond his capacity of control, he may withdraw (regress) later on to a corresponding level of development and the regression may show itself in schizophrenic behavior. The term regression has been substituted for the previous one of deterioration. (See Sigmund Freud)

b) *The psychobiological concept:* Around the turn of the century, the "psychobiological school" became one of the cornerstones of psychiatric orientation and education in America. Its founder, Adolf Meyer, came to the United States from his native Switzerland. He worked initially as a neuropathologist in state hospitals and later on became professor of psychiatry at Johns Hopkins University in Baltimore. He conceived of mental illness as a combination of hereditary or constitutional predisposition and environmental or adaptational social stress. He integrated into his concepts the contributions of Ivan Pavlov

(conditioned reflex), Walter Cannon (adaptational, physiological responses to emotional stress), and of John B. Watson (behaviorism), and he was well acquainted with the teachings of Freud; however, he rejected the theory of an inferred unconscious. The psychobiological school has often been called "the common sense psychiatry of Adolf Meyer" and still exerts considerable influence upon contemporary psychiatric thinking in England and America.

Schizophrenia was viewed as an illness in which faulty habit formations were superimposed upon a hereditary and constitutional predisposition and thus resulted in the behavioral responses that are so typical for schizophrenic patients.

c) *Organic approaches*: Kraepelin assumed the existence of metabolic abnormalities in schizophrenic patients. His thinking has been followed in modern times. During the last fifty years, far greater variety and differentiation of the metabolites of the body have become known. Thus, the presence or absence, the preponderance or deficiency of any of these substances has been investigated with regard to schizophrenic individuals. The observers agree that the alterations observed are, however, often rather the result than the cause of schizophrenic illness. (See *Brain Disorders, Organic*)

Even if at present the results can only be tentative, the following theories can be quoted:

1) Neuroanatomists and neurophysiologists agree that there is a physical substratum for emotion and behavior. This is likely to be located in the developmentally oldest part of the brain, the rhinencephalon, the limbic area, and the midbrain.

2) Biochemists have isolated several chemical substances that are claimed to be present in schizophrenic patients (e.g., taraxecin, abnormal proteins, and carbohydrates).

3) Enzyme chemists have postulated the theory of different enzyme substances that are responsible for the variation or change of normally occurring chemical substances into those that are said to be typical for schizophrenics. (See *Hormones and Behavior*)

However, even if this or that chemical compound should qualitatively or quantitatively be held responsible as a cause of schizophrenia, it still would remain a mystery why the substances would be produced in increased or decreased amounts, and why such alterations would take place at any given time of an individual's life. One might, therefore, say that similar to the psychological causes that have been proposed for schizophrenia, the chemical changes that have been

reported merely hint at internal (innate) and environmentally conditioned (external) precipitating or predisposing factors for schizophrenia.

What is meant by pseudoneurotic schizophrenia?

This condition is characterized by a state of chronic or intermittent anxiety during which persons show a multitude of physical and psychological complaints that are not dissimilar to those exhibited by patients afflicted with psychoneurotic disorders. However, on careful examination during an individual episode or through observation over time, one will find that:

- a) No physical illness is present that would account for the patient's multiple physical complaints.
- b) Transient periods of nearly psychotic behavior can occur.
- c) These patients exhibit peculiar notions and beliefs typical of a schizophrenic feeling and thought disorder.

Is schizophrenia hereditary?

Although there is evidence suggestive of a genetic factor, it is believed that a patient endowed with a schizophrenic potential must not necessarily develop schizophrenia. Rather, an unfortunate combination of a genetic potential and of adverse life experiences would result in actual clinical illness.

This current concept provides the basis for prevention as well as for treatment. (See *Heredity and Mental Health*)

Do psychiatrists agree on a common working concept about the causes of schizophrenia?

Many psychiatric clinicians as well as research workers agree that there may be some unknown, possibly hereditary, predisposing factors in the absence of which no individual can become truly schizophrenic. This factor would determine the way in which a person reacts to overwhelming stress. However, theoreticians and practitioners do not agree about the nature of the environmental stress that may produce the schizophrenic reaction.

What may trigger off schizophrenic reactions?

It is sometimes observed that infectious illnesses, childbirth, or injuries are followed by an emotional upheaval. In such situations, if the patient has a schizophrenic potential, an attack of schizophrenia

may ensue. However, there is no causal link between a specific intercurrent illness and the symptoms of schizophrenia. The same is true for injuries, for menopause, or other endocrine changes. All people go through stages that represent crucial and important events, like learning to walk, going to school, becoming sexually mature, leaving home, getting married, having children, or growing older. It is not the specific situation that determines schizophrenia, but rather the patient's reaction to it. By and large, the older a person is, the more his personality has found an opportunity to consolidate itself and the better able he will be to cope with difficult situations. This may explain why in persons past forty an initial episode of schizophrenic illness is rarely seen.

Are parents responsible for their children's schizophrenic illnesses?

It is a common misunderstanding that the ways in which parents rear a child may or must lead to schizophrenic illness. In fact, one sees that out of a family of four children who have been reared in a reasonably similar way only one child appears schizophrenic. Before the mother is incriminated or accuses herself of reactions unfavorable to the child, or of sins of omission or commission, one should reverse the question. It may also be possible that the sick child because of his different behavior has evoked different responses in the mother or in both parents. Research into a connection between parents' behavior and the occurrence of schizophrenic illness in children continues, but the results are far too tentative for one to convey to the parents that they are responsible or that it is their fault. It makes little sense to add to the tragedy by making the parents feel guilty. Once this vicious cycle has been started, the parents' guilt feelings may promote in them a behavior that will be even less helpful to the child. But parents can be of considerable help if they gain increasing understanding about their children's illnesses and about their own roles and emotional reactions. For this reason the schizophrenic's parents or other significant people who live with him, such as a wife or brother, are often involved in treatment.

What is the age of onset for schizophrenia?

Schizophrenic illness usually begins in adolescence or early adulthood. Certain types, such as infantile autism, are observed even during childhood. The paranoid forms may not become manifest until the age of thirty or even forty.

What are the characteristics of schizophrenic thinking and speech?

It has been said that schizophrenics think as normal persons dream. During sleep no correction takes place between a person's outer and inner reality. Therefore, the dreamer does not think logically, and driven by emotional impulses only, can disregard certain facts of his environment like time and space. (See *Dreams*)

This leads to a peculiar form of thinking that has been called *dereism* or *dereistic thinking*. Just as in autistic thinking, inner experiences no longer take outer reality into corrective account. The more a person's thinking becomes *dereistic*, the greater will be the individuality of his own symbols. Detached from corrective interchange with others, a person may describe a situation or an object with a name of his own private invention. The further this process continues, the less he can be understood. The therapist, on the other hand, attempts to decipher the patient's private code and to help him to retranslate his own symbols into conventionally shared language.

An extreme example of schizophrenic disorder of thought and speech is expressed by the term "word salad." This usually describes a completely incomprehensible type of speech in which words seem to have lost all meaning, yet to the schizophrenically disturbed person they obviously denote some expression of thoughts.

What is the relationship between fundamental and accessory symptoms?

The fundamental symptoms of schizophrenia can be considered an expression of private or autistic thoughts and beliefs that a patient has about himself and the outside world. He fails at a continuous comparison with the type of reality as others experience it. As his own private world prevails in drive and in fantasy, he soon will arrive at conclusions about his surroundings that are logical only to himself. For instance, if he misunderstands certain actions of others, he may react with intensified fear, with complete withdrawal, or with rage and excitement. In each case, the fundamental peculiarity of his own thinking and feeling leads in consequence to a set of new symptoms. These latter symptoms were named "accessory" by Bleuler.

What are the accessory symptoms?

The accessory symptoms pertain to thoughts as well as to physical behavior. The most dramatic thinking disorders pertain to hallucina-

tions, thoughts, and sensations that are based on inner experiences, but not dependent on stimuli from the outside world; to delusions, commonly called false beliefs or logical conclusions based on erroneous premises; and to illusions, defined as misrepresentations of actually existing stimuli or objects on the outside, for example, a mirage. The conspicuous aspects of disturbed physical behavior are noted in extreme and bizarre disturbances of gait and posture. They further encompass general motor activity, whether it is increased to the point of excitement or slowed down to the level of absolute stupor.

What are the earliest indications of schizophrenic disorder?

For both the layman and the physician, it is remarkable when a person without any noticeable external cause gradually takes less interest in outside events. The individual may appear somewhat more remote and withdrawn and be preoccupied with himself. Such preoccupation often takes on the form of ruminations about reasons for one's existence, about the fate of the world, or the "last things in life." The patient may have less ability to concentrate, disregard his physical appearance, and the like. However, such symptoms can occur in many other emotional difficulties such as depressions or the reactions of grief.

It is therefore necessary that a skilled professional person obtain sufficient contact with the patient to search for just those specific discrepancies between thought and mood that are so typical for schizophrenia. One also should avoid attributing such emotional unresponsiveness to ill will, lack of self-discipline, or sheer laziness.

By and large, we distinguish clinically between an abrupt and an insidious onset of schizophrenia. The abrupt form is manifested by extreme anxiety up to the point of panic, while the insidious beginning often resembles a way of life that has also been termed "the schizophrenic surrender." However, many believe that the sudden onset does not constitute the earliest manifestation of the illness, and instead represents an acute decompensation during an illness that previously had remained silent or unrecognized.

How can one distinguish a schizophrenic's ruminations from the normal preoccupations of adolescents?

A distinction should be made as to their degree. Most growing persons go through a stage when they are preoccupied with metaphysical problems or esoteric thoughts, the "last things" in life, and with

concern about their bodies as they develop and about their own worth and the worth of others. Normally, such preoccupations reflect an individual's search for an identity of his own. However, in the adolescent this is only a transient stage, and thoughts and mood vary from day to day, and usually the youngster can be reached or interrupted during such episodes. In contrast, the schizophrenic's odd notions about himself and the surrounding world persist, progress, and soon absorb the patient sufficiently to render him socially ineffective or make him appear detached from reality. (See *Adolescence*)

What mental functions are disturbed in schizophrenia?

Schizophrenics suffer from a discrepancy between thinking and feeling, although they are usually adequately oriented as to their actual environment. Schizophrenic persons arrive at faulty conclusions because their thought processes are influenced by overpowering emotional biases.

What mental functions are principally affected in schizophrenic patients?

Three basic functions seem harmoniously integrated in the wake state of an average human being. They concern perception, affect (feeling tone or emotional state), and intellectual functioning (judgment).

We perceive the outer world through our sense organs; correct appraisal of our surroundings depends on our ability to see, hear, smell, feel, and touch. On the other hand, if for any reason our sense organs are interfered with, either during sleep or through anesthesia, one must guess, so to speak, about one's position in time and space. The individual then relies on an aggregate of experiences that he has accumulated during his lifetime. In schizophrenic patients the functioning of the sense organs seems relatively unimpaired, yet the patients' conclusions about the surrounding world appear to be in error. This suggests that as a result of either overwhelming life stress or as a result of faulty receptor systems, affectivity gains control over intellectual functioning. (See *Perception*)

Can children become schizophrenic?

It is now generally recognized that serious mental disorders that resemble schizophrenic reactions can occur in children between the ages of one and eleven. These children show typical disturbances that are characterized by inappropriate affect and autistic thinking. How-

ever, symptoms and criteria for childhood schizophrenia are not as clearly delineated as they are for adult patients. Particularly in very young children, thought processes need to be inferred from observable behavior, since children in general possess a lower level of verbal facility. It is, for instance, difficult to recognize whether or not a three-year-old child hallucinates. To children the world in general appears animated. A normal young child, for example, often may attribute the power of speech to her favorite doll and hold lengthy conversations with her, but if an adult insists that the statue of George Washington or his wife's tombstone speaks to him, his hold on reality is seriously impaired.

On the intellectual level of mental functioning, a grown-up's ability to think can usually be compared in terms of educational background, age, and social setting, either with others or with his own past performance or attainments. Such comparisons are more difficult with children, since their emotional and intellectual growth not infrequently takes place in phasic or episodic fashion. Isolated traits in children may appear to be schizophrenic. But if these symptoms are viewed in the context of the child's overall growth and development, they may more properly be considered to be within the range of normal behavior. On the other hand, manifestations of childhood schizophrenia also closely resemble the behavior demonstrated by some mentally retarded children, and the differentiation between the two conditions may be difficult. Finally, the motor behavior of children who suffer from brain damage on a congenital or traumatic basis, may resemble the bizarre and repetitive motions of schizophrenic adults.

The manifestations of schizophrenia in childhood are commonly subsumed under the clinical pictures of (a) early infantile autism, and (b) childhood schizophrenia.

What are the causes of childhood schizophrenia?

As with adult schizophrenia, the causes are unknown. The hypotheses for the causes of childhood schizophrenia are similar to those that have been offered for schizophrenia in adults. They comprise biological, social, and psychological parameters.

What are the symptoms of childhood schizophrenia?

Observers agree that schizophrenia in children occurs between the ages of one and eleven. There also seems to be a consensus that between the ages of one and five the symptoms of early infantile autism

may represent childhood schizophrenia. Laretta Bender speaks of a "maturational lag" or "failure of integration of biological development and psychological behavior." The child's overt social functioning is characterized by his inability to make or to sustain meaningful contact with others and by a predominance of autistic thinking. Both can assume the degree of a psychosis.

What is meant by "early infantile autism"?

In 1946, child psychiatrist Leo Kanner described a clinical picture in young children that indicated extreme degrees of withdrawal and failure to establish the usual emotional and social relationships with their elders and peers. These children prefer relationships involving objects rather than persons, exhibit stereotyped mannerisms of behavior and impoverished speech in spite of an average or above average intelligence (for instance, such children could be mathematically precocious and yet unable to communicate in language patterns that would be commensurate to their age levels), and finally their body motions indicate a disturbed orientation in space.

Most observers agree that early infantile autism closely resembles the picture of childhood schizophrenia. They infer that the observable symptomatology reflects "self-absorption," aloneness, and obsessive resistance against any changes during the process of maturation and socialization, and that these symptoms could be equated with the rigid, paranoid thought processes of older children and adults.

What are the general principles of treatment for schizophrenic patients?

As in any other illness, the physician attempts to reduce stress and to increase resistances. In mental illness, stress is reduced by simplification of the environment, as in hospitalization; resistances are enhanced by giving the patient a better understanding about himself in his relationships to others, chiefly through psychotherapy, and by helping him learn new modes of self-expression such as in the acquisition of skills and in occupational therapy.

Can schizophrenia be cured?

A cure in medicine, from a clinical point of view, actually constitutes a state in which the patient no longer has any symptoms of an illness. In mental illness, a cure is better viewed in terms of an adequate level of social functioning of the individual within a given

environment. In a somewhat different way one might state: many schizophrenic patients never have more than one episode, and this may be self-limited. Or they may have intermittent attacks without a general decline. Finally, the earlier and the more wholly the impact of treatment occurs, the briefer may be the episodes of disorganization and the better are the chances for cure. There is suggestive evidence that the gradually improving outlook for schizophrenic patients is based on earlier diagnosis and consequently on earlier treatment than was available before. By and large, all recognized treatment methods seem to be equally effective in such conditions. The selection of the method is a matter of individual medical judgment, and the physician needs to consider a person's psychological, physical, and social assets as well as liabilities in setting up a comprehensive treatment program.

Should all patients with schizophrenia be hospitalized?

In general, psychiatric as well as medical patients should be hospitalized only when they no longer can function in their established settings or when they constitute a danger to themselves or others. The basic principle of psychiatric hospitalization is to reduce the stress that an environment exerts upon a patient and to help him progress from a protective mode of living to more complex relationships with others. With regard to schizophrenic patients, one often has to elect a compromise, and in each individual case it must be decided when a patient is able to return to his previous social and occupational setting. By no means should all patients with schizophrenia be hospitalized, and by no means should all of them be expected to return to the same milieu in which they were taken ill. Between these extremes there are many possibilities for readjustment, such as continued outpatient care, transfer to a less demanding situation, e.g., foster homes, change in occupational responsibilities, and the like.

How are drugs used in the treatment of schizophrenic illness?

Since 1952, potent chemical compounds have been developed, such as tranquilizers and antidepressants, that are highly efficient in reducing the symptoms of schizophrenic illness. Because the symptoms of the illness constitute the disturbing factor in the patient's life and social existence, the suppression or alleviation of such symptoms by drug and total milieu therapy allows the patient to leave the hospital earlier to return to his home or work even if the fundamental psychopathology may still be present. Maintenance drug therapy may be

continued following hospitalization. Drugs may also render a patient more responsive in psychotherapy. (See *Psychopharmacology*)

How are the so-called hallucinogenic drugs used in the treatment of schizophrenia?

The use of the so-called hallucinogenic agents (drugs that can temporarily imitate psychotic, and in particular, schizophrenic-like symptomatology and behavior) is an experimental one at this time. First of all, it is probable that these drugs produce the schizophrenic-like picture less by influencing a person's thoughts and emotions than by interference with normal perception. As these drugs (L.S.D., mescaline) engender states during which the "inner reality" (fantasy) is permitted to outweigh the demands of reality, their actual use would amount to a release of emotion (affect) within the psychotherapeutic setting. Temporarily and theoretically only, these drugs would be of benefit to those schizophrenics in whom "bottled-up" (blocked) emotion prevents a meaningful verbal and nonverbal exchange with others. So far there is little proof that the artificial release of emotional expression by means of these drugs is superior to "ventilation" (catharsis) that can be induced and furthered in a more gradual way during an ongoing, doctor-patient relationship.

How effective is insulin shock treatment and how is it administered?

After an initial period of rejection of insulin therapy following its introduction by Manfred J. Sakel in 1933, there was wide and often enthusiastic acceptance. Gradually enthusiasm waned, and since the introduction of tranquilizing drugs in 1952, the frequency of its use is considerably less.

The technique is a difficult one and requires continuous careful medical supervision. It consists essentially of administering gradually increasing doses of insulin to the schizophrenic patient until coma is produced. A usual course of treatment consists of thirty to fifty such coma treatments—the treatment being given five to six times a week. Coma is interrupted by the administration of glucose. Sometimes the insulin therapy is combined with electroshock. Most psychiatrists who recommend the procedure insist on the simultaneous use of psychotherapy and regard insulin therapy as only one of the tools in the total treatment situation. A psychiatrist who may first recommend tranquilizer drug therapy for schizophrenia may resort to insulin therapy if the drug treatment fails. In general, best results are reported in

those whose duration of illness is less than six months and in the paranoid type of the disorder. It is much less therapeutically efficacious in those patients whose duration of illness is more than two years and in the simple and hebephrenic types.

Does electric shock cure schizophrenia?

Electric shock treatment is nowadays selectively used in the treatment of schizophrenic patients, especially for acute episodes. It is regarded by many psychiatrists as being of great assistance in interrupting episodes of excitement, stupor, and depression.

When can one consider the treatment of a schizophrenic patient successful?

Once contact is established and once the patient has accepted his physician, treatment can be considered to be under way. How long this treatment will take depends on the severity of the illness as well as the goal that physician and patient have set for themselves. This goal is continuously subject to review during the course of treatment. All persons, healthy and sick, must make compromises with their given circumstances. Schizophrenic patients are often so far removed from a factual reality that they tend to delay such compromises. For instance, a grandiose, paranoid schizophrenic patient may for years have striven toward an ambitious goal of becoming an executive in spite of a limited intellectual endowment, a marginal educational background, and obvious inability to apply himself at work. For such a patient, the ultimate compromise, and with this the chances of a more comfortable existence, could be seen in helping him to accept a more modest goal and existence.

What role can the family play?

Unusual aberrant or incomprehensible behavior tends to disrupt the equilibrium of a family unit. Such an assumed balance may be normal or pathological, and one can only arrive at a judgment as to its appropriateness in daily living. Pathological interaction of a family may reflect the fact that the healthy members have become accustomed to the peculiarities of their schizophrenic relative. Should he by chance, or during the course of treatment, recover, the family will need to adjust to the absence of the abnormal behavior instead of the continued presence of interpersonal stress.

For example, a marginally functioning schizophrenic patient has

been too sick to earn a gainful livelihood, but has been able to attend to household chores while he recovers. Readjustments will have to take place. For instance, his brothers may no longer be able to view him with sympathetic understanding or disdain. He may suddenly appear to be one of their competitors. The mother will no longer attend in an exaggerated fashion to his needs and might seek other emotional outlets, while the father would have to reappraise his own opinion about this unfortunate son.

The inclusion of a family into the treatment of a schizophrenic patient tends to readjust the balance in such shifts; it allows for greater latitude in understanding and increasing their own security in terms of permissiveness. (See *The Family in Illness and Health*)

Should schizophrenic patients be hypnotized?

Hypnosis constitutes taking a dominant, suggestive influence upon another person. By and large, schizophrenic patients are severely disturbed and confused in their relationships with others, and the overpowering influence of a hypnotist will only add to their bewilderment. Therefore, schizophrenic patients should not be hypnotized. (See *Hypnosis*)

SCHOOLS AND MENTAL HEALTH

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How should children be prepared for the transition from home to school?

For a child who has been spending almost all his time within the small circle of his family and neighborhood friends, the transition to school is bound to be exciting. His emotions will be an alternating blend of anticipation, fear, and gaiety. The predominating tone will depend on how his parents feel and on his relationships in the home. Whether the first school experience be in a nursery school, a kindergarten, or the first grade, in many communities it has become a custom to have parents bring the children for a first brief visit to see the room and to meet the teacher. If this is done in a matter-of-fact manner on the part of a parent and if the teacher is friendly, the boy or girl usually will be eager to start school.

Is it essential that a child have nursery school experience?

Nursery school and other preschool experience can be valuable in the life of a child. However, it is not essential. The principal effects are to give a child confidence in his ability to enjoy group living and to get along with other adults besides his parents. The evidence of research studies is that on the average there are no dramatic permanent effects. By the sixth grade, for example, the differences between children who have been to nursery school and those who started school in the kindergarten or first grade are too small to measure.

When should preschool education be recommended for the mental health of a child?

This is a highly individual matter. Nursery school is especially valuable for an only child who lives in a neighborhood where there are few other children of his age. Also, many mothers can be more

consistently affectionate and patient if they can be sure of a respite from their children. In some cases, a mother either has to work or feels more complete if she does work. In these cases, the availability of a good nursery school is a godsend to the child. However, if the child feels, either with or without logical reason, that his parents want to get rid of him, then he may resist or resent leaving his home. This will frequently be the case if a younger brother or sister has recently been born, if there are frequent quarrels between the parents, or if his mother has no time for him when he is at home.

Should gifted children be started to school early?

Most schools have a fixed beginning age. For example, they may accept into the first grade all children who will be six or older by October, or April, or some other date. Frequently, parents whose children seem bright will want the child to start even though he is younger than the regulations permit. In some school districts, this can be done if the child meets certain standards on intelligence tests and shows other signs of unusual maturity. The advantage of this type of arrangement is subject to debate.

Although the evidence is not uniformly clear-cut, some studies which have followed up children admitted ahead of schedule have found a number whose later schoolwork appeared to have suffered because of early problems. This is more likely to be true for boys. There is a general tendency for boys to be less ready than girls for the all-important beginning of reading. A child who encounters real difficulty with this type of learning may suffer a loss of confidence or develop other unfavorable attitudes that will handicap him later.

If school officials, after studying a child, are reluctant to allow him to begin school ahead of schedule, parents would be well advised to accept this judgment. If, instead, they consider the decision as a ridiculous affront to their pride and make an issue of the matter, a victory at this point might later be regretted.

Should a parent delay a child's entrance into school?

There are a number of reasons which might lead a parent to delay a child's entrance into school. Because of mental retardation or a physical handicap a child might encounter difficulties in learning or in social life. Some children may behave very immaturely for their age. In other instances, long illnesses may have deprived a child of contact

with other children to the point where his patterns of play cause trouble in the kindergarten or first grade.

However persuasive the reasons may seem, parents should not make the decision to delay the child's entrance without consulting either school officials or a child guidance expert. The larger school systems have programs in special education which may be available even to very handicapped children. In addition, there is always a possibility that a parent's fears of what will happen are not only unjustified but might actually lead to more serious difficulties in the future.

Should children be given toys to increase their intelligence?

From time to time toy stores will display toys or games that resemble items appearing on intelligence tests. Ambitious parents may purchase these in the expectation that as a result their child will get better scores on intelligence tests and possibly be advanced in school. If the toy or game did have the expected effect it would probably mislead school people.

Children do benefit from having wide experiences and a variety of playthings. Also, children recognize that gifts are a sign of affection. Toys of the type described may be fun and may be valuable in their own right. The only problem is in their use for the one purpose of producing a false impression on tests.

Should children be coached in the early grades?

There is no single general answer to this question, because of differences in circumstances. For example, if a child has lost time from school because of illness, most teachers will encourage parents to help the child with the lessons he has missed as soon as he has energy enough to do the work. Again, if a child is puzzled by some aspect of schoolwork and comes to the parent for help, under almost all circumstances the parent should help the youngster by giving hints, asking helpful questions, or showing him how to tackle the problem. (Note that this does not mean doing the work for the child and letting him take credit for it.)

A very different situation occurs when a parent who is eager for a child to make a good showing proceeds to coach or drill the child to help him get ahead in class. Here there are a number of real hazards. For one thing, if the parent teaches reading or arithmetic by a different method than the school uses, the child may be confused and his work may suffer. Even more dangerous, if it is the mother who coaches

a boy, the basis for later emotional blocks to learning may be created. If coaching by the mother results in a boy regarding academic work as feminine or considering success on his part as his being "mother's good little boy," there may be real trouble when he reaches adolescence. Then he may display his masculinity by doing poorly in school or unconsciously prove his independence of his mother by becoming a school failure. These two situations occur so often that they are considered classic cases in books on emotional adjustment in the adolescent.

These difficulties do not appear with any consistency among girls.

What factors in the home affect the child's attitudes toward school?

As far as attitudes toward academic achievement are concerned, children in general, during the early elementary grades, seem to reflect the value placed on achievement by the parent of the opposite sex; in high school, by the parent of the same sex. It would appear that interest in school should be shown by both parents. There would also appear to be unfortunate emotional effects from neglect or lack of interest, on the one hand, and pressure, on the other.

What should be done when a child is afraid to go to school?

Occasionally a child will develop a fear of school. This may be so great that he or she will throw up when leaving the house or while en route. This type of reaction is technically known as school phobia. Usually it has its roots in the relationship between the parent and the boy or girl.

If a child complains of being upset by school, the parent should of course be sure to get the child's side of the story. There are a few poor teachers and bad classroom situations. The parents should certainly go to school and talk over the situation with the teacher or the principal. Usually, it will be obvious that other children are getting along quite well with the particular teacher. However, if there is a suspicion of a possible personality clash and if there are other class sections at the same grade level, transferring the child to another teacher may be a wise thing to try.

If it then becomes clear that the child's reactions are not to a teacher but to school as such or to being away from his parents, the probability is that they are confronting a case of school phobia. In that case, help from a child guidance clinic or other source of professional assistance should be enlisted. In most cases the first move will be to get the child back to school. In general, school phobias are cleared up in a short time.

Most children who have been successfully treated for school phobia during the early elementary grades develop no other difficulties. School phobias that occur in the later years are more serious and may indicate the need for intensive psychotherapy.

What are the reasons a child will achieve markedly below his ability in school?

There are a number of frequently encountered causes for so-called underachievement. These include the following:

- 1) The child comes from a home or a cultural background in which schooling is not highly regarded.
- 2) Due to illness or other causes, he missed or failed to learn early material on which later work is based.
- 3) Although he has learned material or knows how to perform a task, anxiety interferes with his performance. A special case of this situation is so-called test anxiety or examination panic in which the mind "goes blank" at the sight of a test or upon being called on to speak.
- 4) Emotional blocks or learning difficulties in which the learner is so distracted by his emotional reactions that he cannot learn or in which doing poorly serves some unconscious need.

What are the signs that indicate the cause of such difficulties?

Where the cause is cultural the children usually seem to lack interest and this lack is epidemic; it seems to be typical of a large segment of the group. Also, if the parents are called in they prove to be from one of the lower socioeconomic levels and have little ambition for their children. This situation is very prevalent among children of those minority groups most underprivileged.

Where illness or specific lacks are the basic problem, a teacher will be able to discover on questioning the child that he lacks knowledge of some key point. Such cases usually yield readily to tutoring.

Where the problem is general anxiety or examination panic, the teacher will discover that, when tested privately, the child will give evidence of possessing the knowledge or skill he could not produce while under pressure. The child can do the work but needs constant reassurance and support.

Where learning has been blocked or distorted by emotional difficulties, the pattern of errors, misunderstandings, or inability usually seems to make no obvious sense. For example, the child may do

difficult problems but miss easy ones; a syllable he could read at the start or end of a word he seems unable to see in the middle; the problem he solved easily yesterday he cannot even understand today, but will tomorrow. The pattern of his performance may prove to have an unconscious logic but on the surface is baffling.

What can be done about children who are culturally handicapped?

This is one of the most difficult problems that schools are now facing. It is made even more serious now by the fact that the automation of industry is making it almost impossible for poorly educated young people to find any work. The number of unskilled and semi-skilled jobs is decreasing; more and more, high school or college graduation is required for beginning positions.

There are a number of experiments in schools attempting to supply young people from culturally deprived groups with the self-expectations necessary to make them want to conquer their educational handicaps. This involves bringing them in contact with situations in which they can find out that others regard them as capable and in which they can see themselves enjoying those things in life their parents tend to regard as beyond their reach.

If this is done clumsily there is danger that it may make the young people look down upon their parents, and reject not only their parents but those things in themselves which they see as a reflection of their parents. The goal is to develop in the young people a strong, positive self-concept and a level of self-expectation that will enable them to move with a high degree of integrity. Although some of the pioneer experiments have shown hopeful results, much remains to be done.

What can be done about examination panic?

The high anxiety level that results in examination panic and other forms of production difficulty is usually related to home situations, although classrooms clearly differ in the amount of anxiety they evoke. There is even experimental evidence that the type of examinations and the way they are given can modify the anxiety sufficiently to result in great differences in the scores earned on identical tests given under different conditions.

By itself, examination anxiety does not require treatment of the individual concerned. Of course, when it is accompanied by other symptoms, such as excessive timidity, depression, or disorganized behavior, the larger problem may require some form of psychological help.

Where a young person has difficulty in displaying his knowledge or skill, the wise teacher usually gives him an opportunity to do so under less trying circumstances. Where the procedure of a class evokes outbursts of panic, there is need to rethink the pattern of the class itself. It is highly questionable whether there is justification for such situations.

How does anxiety affect learning?

Traditional education, especially in many European school systems, has put much pressure on children "to learn." Examinations, contests, threats, and even corporal punishment have been used to create an incentive to learn whatever it was that teachers thought had to be learned.

There has been a considerable amount of experimentation with the effect of anxiety on learning. In summary, these experiments show that high anxiety can increase efficiency in rote memory and such simple tasks as learning nonsense syllables. However, more complex types of learning quickly deteriorate under anxiety. Solving problems ingeniously does not usually occur when a person is panic-stricken.

If the goal of a school system or of a teacher is to encourage creativity, low anxiety levels are essential. If the goal is to teach word-for-word reproduction of an unconsidered formula, high anxiety does the trick.

What can be done about emotional blocks to learning?

The variety of emotional blocks to learning is very great. In some cases, a word or a number has so frightening an association for a person that he distorts material to avoid using the fateful symbol. In other cases, the situation is more complex. At the Judge Baker Guidance Center in Boston, for example, they have encountered a number of boys who have trouble in reading, who come from families in which the father is something of a failure, the mother is an ambitious, driving person, and the boy is unable to give normal expression to his aggressiveness. When asked to read, these boys become engaged in fantasies that distract them from their reading. Under treatment the boys show an intricate combination of reactions which, among other things, include fear that successes would make them unacceptable to one or both parents, plus a hidden delight in the concern that their poor performance may arouse. It takes years of intensive work with the boys and their parents to make even a dent in this pattern.

There are a great many other situations that can give rise to learning

difficulties of emotional origin. Some young people act as though their goal were to fail; others act as though to satisfy curiosity were wicked; and still others as though their objective were to become and stay dependent upon adults. Such feelings, either singly or in varying mixtures, can prevent a child from using his abilities with normal efficiency.

Although progress has been made in describing causal patterns, the psychological treatment of emotional learning difficulties is regarded as among the most difficult of psychotherapeutic tasks. In some cases, remedial instruction by itself is effective; in others a combination of remedial instruction and psychotherapy will work well. In general, once it is determined that the underachievement of a boy or a girl is largely due to emotional causes, therapy offers the greatest promise. This is an area in which much research and study is going forward, and it is hoped that in the future better and more certain methods of dealing with the problem will be found.

What proportion of schoolchildren are emotionally disturbed?

Mental health surveys of school systems, although different ones use somewhat different criteria, appear to agree in finding that approximately 3 per cent of the school population is suffering from serious psychotic or prepsychotic conditions requiring intensive treatment, and that another 10 to 12 per cent, having milder troubles, would benefit from some form of special help. That means that if a teacher had a class of thirty-two children, on the average four would have some recognizable psychological difficulty; of the four, one ought to have immediate psychiatric assistance.

How can these children be recognized?

Experienced teachers are remarkably capable in identifying children who are likely to become either delinquent or emotionally disturbed.

In the late 1920's a study by E. Koster Wickman showed at that time that teachers were more likely to react to defiant or aggressive behavior, while trained mental hygienists were more concerned about withdrawn or excessively shy children. Within recent years there have been several repetitions of this study; today the findings indicate that teachers do give more weight to the symptoms that are regarded as serious by psychological workers and that experts in the field of mental health are more concerned about so-called "acting-out" behavior. Recent studies, following up early clinic populations after a period of fifteen to thirty

years, indicate that antisocial behavior in childhood must be taken very seriously; the teachers were right.

In a well-equipped school system, if teachers were asked to suggest children who ought to receive special help and if these suggestions were checked by careful psychological tests, more verified cases needing treatment would be brought to light than existing facilities could handle.

What preparation do regular teachers have for dealing with emotionally disturbed children?

In view of the fact that throughout the United States (and in all other countries) the number of institutions and other facilities for treating emotional disturbances of children is far below the need, and in view of the additional fact that there is little likelihood that special classes will be provided to accommodate even a small fraction of those requiring such assistance, teachers in regular classrooms will remain the principal resource for dealing with emotionally troubled children.

At present most teachers in the course of their preparation do have the benefit of work in the fields of educational psychology and child development. Only a small portion of this work is adequately focused on the problems of dealing with such children in the context of normal classrooms. As a result, in a number of localities, there has been experimentation with in-service programs for teachers. Some have been sponsored and operated by teachers colleges or universities, and some have been sponsored by mental health associations or private foundations. There also has been some study of the advantages of providing psychiatric or psychological consultation to teachers to deal with such problems. The results of these measures appear to be heartening.

In general, when in-service programs of the type described above are put to objective test consistent good results are reported. The teachers concerned are observed to have fewer conflict incidents in their classrooms, absences and tardiness go down, and the classes show a slight improvement in their academic work.

Does an only child have special problems in adjusting to school?

Every child has his own individual problem of adjusting to any new situation, including school. However, merely because a boy or girl has neither brothers nor sisters does not mean that he is bound to encounter serious problems. On the average, an only child has no more emotional upsets than children with siblings. There is some tendency, however, for an only child to be overprotected.

If we were to answer only in terms of average situations (there are always many exceptions), the probability is that an only child in school will show a slight superiority in the reading and language skills, and possibly have difficulties in social relationships. However, where the parents of an only child have made sure that he has had plenty of opportunity to play with other children and to have friends of his own age, none of these conditions are likely to prevail.

What should be the relationship between parents and teachers at the elementary school level?

In most school systems in the United States, parents and teachers usually try to exchange information about children and to work in partnership. The widespread popularity of parent-teacher associations, many organized in the National Congress of Parents and Teachers, symbolizes this development. Most schools have opportunities for parents to come to school for the purpose of learning about the school's program and also to provide some contact between parents and teachers. Usually if a child is having difficulties in school, teachers seek a conference with his parents.

So important do many schools regard the parent-teacher partnership that there has been a great deal of experimentation with ways of improving it. Some schools arrange for special days on which teachers may either visit homes or have conferences with parents in their school-rooms. A few school systems either replace or supplement report cards by having scheduled conferences between the teachers and the parents.

In elementary school what social life does a child have?

As most parents and teachers know quite well, school is not only a scene for intellectual learning, it is also a social situation. A child's success in school in the intellectual realm may be vitally affected by his social life. There is some research which hints that in a child's life, preoccupation with interpersonal relations takes precedence over academic learning. If a child is deeply worried about how he is getting along with a teacher or his classmates, it can distract his attention from learning.

When children start kindergarten they usually are able to play well in pairs, but without supervision are likely to fight if there are three or four. In the kindergarten room, with a teacher to help the children manage situations, the size of the play group may increase. However, on the way to and from school, as well as in the neighborhood of the

home, there are likely to be frequent tearful episodes. These are usually of short duration; the child who is driven from the small group in tears today may be playing happily with one or the other of his erstwhile tormentors tomorrow.

In the third or fourth grade, the groupings within classes become more fixed. At this age some children are already acquiring so much success experience that they can predictably be marked as possessing social skill. Others are relatively isolated, or may even be rejected. Skillful intervention by teachers, who, for example, pair popular children with less adept classmates in performing tasks, may change the situation for the better. Improvement in a child's social position in a group at the third grade level may have effects that last for years.

Toward the end of the elementary school, children are approaching the period of preadolescence; for them social life may seem of critical importance. In general, most eleven- and twelve-year-olds appear to be hungry for group membership. Many become embedded in cliques. There is a healthy minority at this same age, however, who go in for solitary pursuits and become avid readers or hobbyists. Between these two opposite segments of the class are an unhappy few who badly want to be in good with other children but who are either rejected or must remain on the fringes. Parents and teachers who are trying to decide whether a relatively isolated child should be considered as having problems would probably be well advised to pay careful attention to the child's general feelings. If a child seems to be happy by himself, engages in a variety of activities which clearly capture his interest, it probably would be of little use to attempt to make him "more social." On the other hand, if he is miserable in his isolation, tries to satisfy his social hunger by bossing a group of smaller children, or fastens anxiously to a narrow range of activities, there may be a problem with which he needs help.

What roles do the school and the home play in handling such situations?

For children in the kindergarten and primary grades, both home and school can effectively play a direct role in helping children cope with social problems. Parents can help a child by providing a place where friends are welcome to play with him or her and by giving the child enough playthings so that with a friend or two there will be a chance to shift activities. The playthings need not be elaborate or expensive; it is more important that they be rugged and adaptable to

many creative uses. At school, teachers can help by placing a lonesome child with a group or by telling him directly how to join other children in their activities.

For children in the middle range of the elementary school grades the home can continue to do its part by providing space, playthings, even snacks. However, there is a risk that if these welcomes are overdone to the point where they look a bit like bribery, both the child and his friends may take these to mean that the parents have no confidence in the ability of their child to fend for himself. A similar caution should be given against parental interference in arguments or other juvenile conflict. If a playmate does something that may be harmful, it would be better to make this the subject for a talk between adults, and then only if there is little likelihood that punishment might cause friction. At school, in these same age levels, teachers may aid children by the way they form groups within the class for various class projects. Also, boys can be helped by direct teaching of the game skills that later play so significant a role in the ability of a boy to participate in the traditional activities of his age-group. This is the age of games, and of helping children learn how to play them.

At the conclusion of elementary school, children are striving to be independent; the parent or teacher who intervenes too directly in arranging social events or in attempting to settle arguments may be causing real trouble for the child whom he seems to favor. The home can continue its role as a gathering place. If the neighborhood favors junior divisions of the several scouting organizations, a parent may volunteer for leadership. (Parents should not be disturbed if during the group meetings their own children are the ones who act up; the child is merely displaying his own independence.) Schools can now begin to arrange social affairs and develop extracurricular programs. Children who are not popular can be given indirect help by watching how they behave toward their classmates and giving them suggestions on social skills. Incorporating unpopular children in various work groups may be effective if the group contains a leader who has not tried too hard to be popular and who also has a helpful sensitivity toward people. There is no simple recipe for good grouping. Often first attempts merely point to the necessity for further trials along new lines.

What are some of the disciplinary problems in the elementary school?

In very general terms, the main problems encountered in the kindergarten and first two grades revolve around the fact that the children

are still too young to have reliable self-control over all the conduct required for group living. In addition, they want attention and affection from teachers. When they see or think they see other children misbehave they will tattle. Thus, teachers in the early grades have their problems in developing group activities at a time when children may be clamoring for individual attention.

In the middle grades, in most well-run classrooms, problems tend to be confined to a minority of children who may engage in disruptive conduct either because they are bored or befuddled by material outside their abilities or else they may have some type of emotional upset. In these grades, then, the chief problems tend to involve the deviant but often quite persistent behavior of a few individuals.

In the closing grades of the elementary school, the class as a whole may occasionally be involved in group support of rebellion, defiance, or imaginative mischief. Also at this age level in a given class there may be very good days and very bad days. Occasionally within a school, one class section may develop and cherish a reputation for being hard to manage. Teachers at these upper levels must develop an ability to see unexpected events with perspective and humor. Parents should not be taken aback if occasionally even the nicest children come home indignant at some purported outrage attributed to a teacher and, together with classmates, plot retaliation. Usually, after everyone has reveled in the contemplated rebellion, the children go meekly to school the next day. For both teachers and parents it is important to recognize that the children need and appreciate adults who can help them keep their impulses under control. At the very age when youngsters seem most up in arms against firm discipline they also consider inability to keep control as the most serious defect in a parent or teacher. This confusing paradox is typical of preadolescents, an age-group that can be very baffling.

What measures are the key to good discipline in the classroom?

Experts have identified more than twenty so-called influence techniques or intervention procedures by which teachers and other group leaders can help a group work at the necessary level of behavior. It would be fruitless and confusing to list all of the specific devices. More helpful, perhaps, would be to mention a number of general principles.

The few careful experiments involving scientific study of discipline indicate that in general there are fewer problems in classes where the teacher maintains an atmosphere of stimulation, where the require-

ments are clear, and where the children feel the teacher is fair and understanding.

When the teacher must intervene because of the behavior of a child or a group, the most important thing is that this be done in a way that makes the issue very clear. If clarity can be attained, then the specific device to be used should be the one that obtains the voluntary acquiescence of the individual with a minimum disruption of the group. For example, if a child is talking, it would be better for the teacher to obtain quiet by clearing his throat than by slamming down a book while shrieking, "Quiet!" A full listing of the several influence techniques with their advantages and limitations is referred to in *Controls from Within* (also published under the title *The Aggressive Child*) by Fritz Redl and David Wineman, or *Mental Hygiene in Teaching* by Fritz Redl and William Wattenberg.

Because of the disruptive effect, most authorities on the subject regard corporal punishment as unwise. However, it still is used in many American schools, and it is standard practice in the schools operated in the British and German traditions. In the United States the legal situation varies from state to state. In some states there are statutes expressly forbidding corporal punishment of any kind. In others, the schools are considered to be *in loco parentis* and are empowered to use any measures a conscientious parent might use; courts have interpreted this to include physical chastisement.

When parents feel that the measures used by a teacher are questionable it is usually important to make sure that the child's story is accurate. If it is, discussing the matter with either the teacher or the principal is often helpful. In some instances, it will be found that the teacher was justified and that the parents should support his action; in other cases, the action may be contrary to school policy or was indeed unwise and school people will be happy to correct the situation; in other lamentable instances, there may be no meeting of minds but the incident will become part of the long train of events that helps to form public opinion.

Does a child think of a teacher as a parent-substitute, even to the point of rejecting his own parents?

In the technical language of psychologists, every teacher serves some children as a parent-surrogate. This means that the teacher takes on some of the psychological functions of a parent to the child. Usually

this role is performed in only a few limited areas for a short while. However, a few parents become jealous when they find that in a household discussion, for example, a child expresses a point of view different from the parent and obstinately holds to this contradiction by citing the teacher as a final authority. In some instances a father may find that his son admires some man teacher more than the father; or a mother may find that a girl reveres a woman teacher.

During preadolescence or early adolescence, when a child is moving toward independence from the home, the idolizing of a teacher may serve the boy or girl as a means for prying himself loose from attachment to a parent and, at the same time, holding to a socially desirable standard of conduct. In some instances, of course, the child may be seeking in a teacher some qualities absent in a parent.

For teachers, the strongest instances of this type of relationship often occur when a parent is absent from the home or is ineffective. For example, children from broken homes may attach themselves to a teacher, as may a child whose parents are too busy to give him much attention. Also in schools in underprivileged areas, children may seek to identify with a teacher rather than with a parent who is unable to cope with the general mores of our society.

At a less dramatic level, children may displace emotions from a parent to a teacher. Thus a child who is seeking independence but does not want to defy his father or mother, may behave rebelliously toward teachers. Young people who have a depth of affection for one parent which leaves them feeling uneasy, may develop a "crush" on a teacher of the opposite sex. There are innumerable variations on these themes. In general, when a child's reaction to a teacher is excessive some such displacement of emotions from the home may be suspected.

Why would a high school student not want to go to school?

By the time high school is reached, a young person's feelings have been developing for a long time. Many are getting ready to quit as soon as they reach the legal age limit. Meanwhile, they may be showing their distaste in truancy.

Studies of "early school leavers" show that many had trouble with reading or arithmetic in the primary grades, that many come from homes where schooling is not highly valued, and that many are not taking part in the extracurricular activities.

A special situation arises where the young person involved is one of

fine ability whose parents are anxious for him or her to get a good education. If the pressure in the home came from the parent of the opposite sex, the adolescent rebellion may take the form of a serious deterioration in schoolwork. Psychiatrists who have worked with such cases report that it is almost as though the youngster's chief ambition is to fail.

Where a secondary school pupil develops a strong distaste for school it is time to bring a trained counselor into the picture. The counselor can determine, if anyone can, the reasons for the dislike and what, if anything, can be done.

Among children who belong to minority groups or come from culturally deprived homes, schooling may seem to be a waste of time and energy. Where there really is discrimination against certain racial and nationality groups in particular fields of employment, this feeling may be a realistic one. A number of experienced psychiatrists who have been called upon to examine young people of high ability who come from certain strata of society and who have refused scholarship opportunities report that many of them are in very good emotional health—they are responding adequately to the values of the society in which they live. To counteract the waste of human resources represented by this situation, discrimination itself must be attacked.

What can be done for or about unpopular high school students?

At the high school level, social maladjustment can be a serious matter in many ways. For one thing, the student with unsolved social problems cannot make full use of his intellectual energies. For another, his unhappiness is a matter of weight in itself. Also, if the situation persists there may be even more serious trouble ahead.

As to reasons for unpopularity at the high school age, these are as many and diverse as those for unpopularity among adults. In some cases this may be a reaction against group allegiances in terms of race, nationality, religion, or socioeconomic class. More often, the unpopularity is a reaction against personal qualities such as hostility, immaturity, or erraticism. Only in exceptional cases where the I.Q. is extremely high will it be due to giftedness alone.

Since the reasons are too many for any concise statement, the problems must be tackled each in terms of its own causes and its own setting. This again is a matter where the skill of a trained counselor will wisely be brought in.

What are the qualities usually found in high school leaders?

High schools differ in the pattern of qualities which students value; also each group activity may require different qualities in the leaders. Among boys there is a strong tendency to value athletic prowess, resourcefulness, and brains. Among girls, social skill, popularity, and a pleasant appearance have been listed as assets in many studies. It is often found that among both boys and girls the leaders have sensitivity for the needs of other young people, are helpful, and have a capacity for organizing activity. One list, typical of many such, describes the qualities which Raymond Kahlen and Beatrice Lee found held true for both sexes from grades six through twelve in New York State:

1. Active in games
2. Enjoy a joke
3. Initiate games and activities
4. Willing to take a chance
5. Neat and clean
6. Like the opposite sex
7. Enjoy a joke on themselves
8. Cheerful and happy
9. Good-looking
10. Enthusiastic

What should be the relationship between parents and teachers at the high school level?

As a general rule there is considerably less contact between teachers and parents at the high school level than is true for the elementary school. On many issues the young people would rather take the responsibility than have their fate decided in their absence. As a consequence in a number of schools one finds parent-teacher-student associations.

There are some questions on which consensus among adults appears highly desirable. For example, in some communities, the young people play adults off against each other with the result that there may be a dangerous lack of agreement as to the hours at which students are expected to be home from dates, on allowances, or on the use of family cars. When the issues involved are discussed by the adults, preferably with the participation of youth, sensible arrangements may be reached and an element of order introduced without creating friction within families.

Generally, counselors at the secondary school level deal directly with the students; parents are drawn into the discussions mainly when deci-

sions as to the future of a boy or girl involve parental ambitions or require parental assent. There is a good reason why counseling need not involve parents on many issues. Whereas little can be expected in the change of a younger child unless there is an alteration in the home situation, adolescents have reached the point where their problems may concern their own feelings and their own attitudes toward themselves. Therapeutic processes can be based on the development of their insight and can take effect without requiring a change in the home. Where decisions are made concerning future plans, however, parental reactions may be of considerable moment to a young person. Therefore, their participation in the decision-making process may be essential. At the same time it is recognized that the developing independence of the girls and especially of the boys must be respected. Accordingly, many counselors will contact parents only after discussing this with the students.

How do relationships change at home during this period?

As a general rule, boys and girls during the high school years are establishing psychological autonomy and their own personal sense of identity. They have to develop a perception of themselves as being people in their own right, and as having a personal continuity. Of necessity, their relationships with their parents will change. The exact nature of this change depends so much on the many facets of the previous relationships that no universal formula holds true for all adolescents.

As they move toward adulthood, the young people will want to have the feeling that their beliefs are really their own, that their tastes are truly theirs, and that in important areas of living they are self-activated. At times the best way to establish this autonomy to their satisfaction is to stage a personal revolt. At other times to feel superior to their adults seems to be a need. This superiority may take the form of having higher ideals, different tastes, or even sharper doubts.

As a usual thing, boys seem to move faster toward independence, seem to feel less understood by their parents, and flaunt greater autonomy than is the case for girls. Boys in adolescence share fewer confidences with their fathers than girls do with their mothers.

While the need for interest and supervision by parents remains quite important, many adolescents resent intrusion into their affairs. They may hold certain privacies as very important. Only when they are sure

their autonomy has been established will they return to the flow of confidences that may have held true at an earlier age.

What are the disciplinary problems in the secondary schools?

Once the students have outgrown the tumult of preadolescence, there is a strong tendency for classes to settle down. To put the matter somewhat oversimply, adolescents show an inclination to practice being adult and they will often cast themselves in the role of assistants to teachers, group leaders, and even parents. As a consequence, toward the end of the ninth grade or the beginning of the tenth, classroom groups tend to become more manageable. If disciplinary problems occur, they seem to develop from one or a combination of three causes: (1) Students who are likely to become "dropouts" have lost practically all interest in school and frequently combine an unwillingness to do any academic work with a penchant for delinquent or semidelinquent behavior patterns. (2) Young men and women who have disturbed personalities are getting into much more serious mischief. (3) For the rare teachers whom students regard as hostile or as incompetent, organized counterattack by the class may develop.

In general, teachers find that those young people who expect to continue their education are annoyed by classmates who interfere with classroom activities. Therefore, many disciplinary situations can be handled by having classroom discussions to bring the group standards into the open; afterward the teacher can take the role of spokesman for the group. Firm statements of expectation by the teacher, occasionally reinforced by penalties, will usually have class support, and will be effective. For the disturbed personalities, referral to counselors is almost always necessary.

Is expulsion from school an effective measure?

No single method of dealing with people is ever good for all or bad for all of them. There certainly are some occasions where expulsion may be justified to protect a group from an individual whose very presence has bad effects. Also, there are some cases where neither a young person nor his parents will recognize the need for seeking treatment or other help until the school expels him. In both these situations expulsion may be the best thing.

Such situations, however, are rather rare. If a young person is suffering from emotional disturbance, little is gained by cutting him off from the one institution that may be in a position to help him. If he has

an unfortunate pattern of values, it hardly seems sensible to cast him beyond the influence of educators. Expulsion usually is an evidence that school people have lost patience with a boy or girl for whose behavior trends they have found no adequate method of coping. It is a sign of desperation. Usually when expulsion has been used, a careful stocktaking for all concerned, school people, parents, and the boy or girl, is advisable, especially after the emotions surrounding the expulsion have had a chance to calm down. Generally, something is very wrong and needs to be corrected.

From a mental health standpoint, what should be said about compulsory attendance laws?

Throughout the United States there are state statutes requiring children to remain in school until they have reached a specified age. The original reasons for such legislation were related to the serious effects involved in the exploitation of child labor. In view of the fact that school may become intolerable for some children there have been several strong pleas made to modify these laws so that young people who would benefit from release from schools or gain from the experiences of employment would be permitted to work. On the surface, the arguments for such modification seem quite appealing. However, there are powerful counterarguments.

For one thing, labor organizations are unlikely to yield in their opposition to exposing adult workers to wage competition from child workers. They note that the well-intentioned advocates of early work are quickly joined by employing groups notorious for their past exploitation of children.

Second, present trends in employment possibilities in the light of automation mean that the only jobs available for relatively poorly educated young people are in the unskilled and semiskilled classifications for which the future is most bleak.

Third, the fact that a boy or girl finds school intolerable is a criticism of the school program rather than evidence as to the merits of full-time employment. The solution to such problems involves careful remodeling of the school program. Serious educators have found such modification quite possible; in a number of places young people who once would have seen no point in continuing their education, now not only willingly stay in school but also see their job skills significantly upgraded by school experience. In Detroit, for example, many young people, who left school early, returned to school after brief experience at

work, resulting in the realization of the occupational handicap imposed by inadequate schooling. The so-called job-upgrading program gives them an education based on their needs and their abilities.

And finally, where a young person would benefit from the fine experience of having the kind of responsibility entailed in employment, this can be arranged in many places as part of his school program. Many schools throughout the nation now have various versions of work-study plans, or cooperative work plans. Under these, a young person spends about half his time working for pay in a business or industry, and spends the other half in classes. The employment situation is arranged and supervised by school personnel.

From a mental health standpoint, many children now benefit from having some employment. However, they can enjoy this benefit under existing legal arrangements. There is no mental health sanction for the destruction of legal safeguards against child labor.

How can schools or parents help a student reach decisions about future education and vocations?

Most first-class school systems have counselors and programs for both vocational and educational guidance. This is considered an essential aspect of any sound educational program. If a school lacks this type of facility, the parents and the community as a whole ought to be concerned about the situation.

In the better schools, the children in their classes are given some opportunity to learn about occupations, to find out about the types of work that might interest them, and to learn about the educational requirements for those occupations. Often, they are encouraged to talk matters over with their parents. This is good and useful.

For certain young people problems nevertheless may arise. Some are not sure of their own abilities or their interests. In other cases, parents are anxious that the child either reach the decision they want or just reach any decision.

People differ in this area as in all others. There are some who decided what they wanted to be before they were thirteen, who followed their childhood dreams, and who have been successful. Others, equally successful, did not find the occupation that suited them until they were thirty. Equally true, some who made and followed early decisions have regretted it deeply, and so have adults who drifted aimlessly all their lives. Neither early decisions nor late ones are good in and of themselves.

The role of the school and of the parents is to help a young person find the opportunity to get the information he needs, to have the experiences he requires, and to talk matters over to his own satisfaction. There is no way to coerce a decision with any assurance that it will be a good one. Having made clear the realities that at a given time a young person must make some decisions, the role of the adult is to help the young person find himself. In some cases this may require great patience. There is always a possibility that a young person has a strong inclination which he feels will upset parents or teachers, and for this reason feigns uncertainty. It is also possible that interpersonal tensions at school or at home may be the source of indecisiveness. Whatever the situation, the parent or the teacher who encourages talk and thought is likely to be of ultimate assistance.

What are the signs of good mental health in adolescents?

The mentally healthy adolescents tend to show an effective range of emotional reactions, to be capable of deriving pleasure from small things, to have good relations with others of their own age, to be capable of having fun, to be spontaneous, and to communicate well. In addition, they will show real interest in the opposite sex. They will tend to be able to think in terms of the future. Interestingly, if they have done a wrong or inflicted an injury on someone else, they are likely to try to make amends rather than just "feel sick" about it.

What are the signs of emotional disturbance in adolescents?

This is both a serious and a difficult question. What makes it serious is that with adolescence the incidence of disabling mental illness begins to rise. One of the most serious of all mental diseases is that of schizophrenia appearing during adolescence. Hospital statistics show that child admissions to mental hospitals increase tenfold during the later teen years. Moreover, the outlook for adolescents treated in mental hospitals can be poor not only because of the difficulties involved in their treatment but also because of the problem of readjusting to everyday living.

The hard aspect of the question is that adolescence itself creates conflicts which, however, usually resolve themselves. Psychiatrists find that their skills are put to quite a test when diagnosing adolescents.

With adolescents as well as with young children a good rule is that if parents or teachers are worried over a young person's behavior, instead of attempting a diagnosis they should promptly make arrangements

for the young person to be seen by the best-trained psychiatrist or psychologist available. Despite the fact that spontaneous recoveries can take place, the words most to be rued in many cases are, "Leave him alone! He'll grow out of it!" If he doesn't, a whole life can be wrecked.

Although many symptoms point to the possibility of mental or emotional disease, there are five major groupings which must be taken very seriously:

- 1) If an adolescent seems to be excessively shy, withdrawn, or seclusive; if he or she seems to live in a dream world from which he returns only with difficulty or resentment, something may be very awry.

- 2) If there is a tendency to be very depressed, to show an extreme lack of energy, or to react to disappointments with feelings of worthlessness or with thoughts of suicide, this reaction may be related to psychotic depression rather than everyday adolescent moodiness.

- 3) If the young person seems beset by an unusual amount of suspiciousness; if his or her world seems to be peopled by schemers of diabolic cleverness; if he tends to turn the edge of his suspicions especially against people who attempt to befriend him, these may be signs of paranoia.

- 4) If there seems to be an unusual amount of physical illness, especially if the complaints seem to be vague or only passingly related to organic troubles or genuine infections, a physician's judgment should be obtained as to how much of the illness is psychosomatic.

- 5) If there are many episodes of antisocial behavior—fighting, stealing, wild driving—the lack of inner controls may betoken a disabling personality disorder.

Indeed, if a particular adolescent seems to have emotional reactions unusual for adolescents, there may be cause for careful observation. Although it may sound a bit unscientific, it should be remembered that most teachers have had considerable experience with adolescents and have developed a good sense of how they act. If an experienced teacher feels uneasy about a student, this in itself may be significant.

In view of the fact that one cannot take action unless a problem is recognized and in view of the equally evident fact that both a young person and his parents will be healthfully relieved if their worries are definitely terminated by the finding that the boy is in good condition after all, we can revise a bit of old folk wisdom by saying, "It's better to be sure than sorry."

SCHOOLS: MENTAL HEALTH SERVICES

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What services are available in school systems for young people having emotional problems?

Provisions vary widely. Most well-equipped school systems will have one or more of the following: a central child study bureau, school psychologists, school social workers, remedial instruction teachers, guidance counselors, and special classes.

What are the differences in services for elementary and secondary schools?

Because of the great power of home situations for elementary school pupils on the one hand and the ability of high school students to profit directly from counseling on the other, the elementary schools are more likely to rely on school social workers and the secondary schools to provide guidance counselors, although this difference is not an all or none matter. Also, because decisions as to placement in special classes for intellectually handicapped children must be made as early as possible, elementary schools must be provided with adequate diagnostic services, usually represented by psychologists.

What is the function of school social workers?

In some states the school social workers, also known as "visiting teachers," are as the name implies, social workers who have training for work in school settings. The precise statement of qualifications differs from state to state. In general, they are required to have both teaching experience and social work training.

Under usual conditions, school social workers are assigned to elementary schools and divide their time among several. Within recent years there has been a tendency to assign them to secondary schools as well.

When a teacher is concerned over a child's behavior the case may be

referred to a school social worker, who will make the arrangements to obtain a reliable diagnosis of the difficulty and take steps to refer the child and his family to the appropriate treatment resource. Usually, the school social worker will contact and work with the parents to help them directly in their relationships with the child and to enlist their cooperation in obtaining the diagnosis and in arranging for treatment.

What is the function of school psychologists?

Here, again, there is much variation both in the title of the position and in its requirements. In some states, there may be two or more types of school psychologist. For instance, some, called school *psychometrists* or school *diagnosticians*, may be largely limited to the giving of tests and the interpretation of their results; others may undertake correctional programs or act as consultants in the development of school policy.

Where a school system provides school psychologist service, children who present problems to teachers are usually referred to the psychologists initially for testing. The psychologists generally begin by determining the level of intellectual functioning. Where appropriate they may gather data as to the level of social adjustment and emotional stability. If the problem centers around mental deficiency the psychologists may recommend that the child be placed in a class for mentally retarded children. If emotional difficulties are the main issue, the school social workers may be brought into the picture or the psychologists may undertake to work with the family in arranging for treatment.

Studies of what happens in practice reveal that the major difference between school social workers and school psychologists is that the psychologists give tests and interpret the results at the start of their contact with a boy or girl. After this beginning there often is little difference in the work done by the two types of worker.

Do school systems employ psychiatrists?

The larger school systems usually have some arrangement for obtaining psychiatric consultation. The exact arrangements differ widely. The norm would appear to be either a part-time employment or a case-by-case referral. The psychiatrist is generally used to give diagnoses and to suggest referrals; only rarely will he engage in actual treatment as part of his role in the school system. Where a school system employs a psychiatrist either full time or part time, a good portion of his con-

sultation may be connected with those activities of the school medical department concerned with the selection and retention of teachers.

What is the role of counselors?

Almost every secondary school of any size will have one or more counselors or guidance workers. They are usually teachers who have had additional preparation to equip them for guidance and counseling. One of the provisions of the National Defense Education Act was to provide federal funds for the training of additional counselors.

The counselors almost always help students in choosing their programs, and may also offer guidance in arriving at vocational decisions. Young people frequently either go to the counselors or are sent to them for help with personal problems.

In some cases, the counselors are expected to act as the secondary school equivalent of college deans and may be kept busy checking on absences or dealing with disciplinary problems. This is regarded as an unfortunate use of their time especially as it may be incompatible with assisting in true counseling on important personal difficulties. The available evidence indicates that personal problems counseling may be very influential in enabling adolescents to cope successfully with some of these problems.

To what extent do schools offer treatment for emotional problems?

This is a tricky question. Its answer depends on the definition of "treatment," which is itself a problem. If by treatment one means intensive or long-term psychotherapy, it is rare indeed for school systems to become involved in such activity. Therapy that approaches psychoanalytic treatment in depth is a costly enterprise. School personnel rarely has the requisite training; school budgets are seldom adequate to support the financing of full-fledged therapy for any significant number of children.

However, if the term "treatment" is shorn of its medical meaning and is taken to encompass remedial instruction, social casework given in a few interviews with parents, or counseling in occasional sessions with students, then it is a frequently rendered service. In some school systems, the psychologists and school social workers may engage in play therapy or interviews with a small number of young people.

As a matter of course, teachers make allowances for individual differences. They may give special attention to children who are having difficulties; they may show personal interest in children; they may ex-

tend both tutoring assistance and help with social relationships. Although such activities might not be dignified with the term "treatment," they may be quite effective in helping a given boy or girl surmount his or her problems of the moment. In doing so, this may have an influence in later development.

As may be judged by the foregoing, the tendency is for most school systems to draw a line at activities that would require medical skill—the use of medication or depth therapy.

What do schools do about children who need therapy?

Where the nature of a child's difficulties call for some form of prolonged or intensive treatment, school systems have to depend upon other community resources. These include child guidance clinics, treatment homes, casework agencies, and private therapists. The school system refers disturbed children to these other facilities.

In practice this usually means that a school psychologist, a school social worker, a counselor, a teacher, or a principal talks the matter over with the young person's parents and may help them to contact the suitable resource. Although school personnel may smooth the way, generally it is the parents who must, in the final analysis, take the initiative.

What authority does the school system have?

In most states, the parents and the parents alone have the authority to arrange for treatment of their children. In extreme cases, schools have the power to bar a child from school if he is ineducable or is a menace to other children. However, the vast majority of emotionally disturbed children, like mentally ill adults, are pathetically withdrawn or docile.

This means that school personnel in almost all cases of emotional disturbance have to rely upon persuasion alone in getting parents to accept referral to a source of therapy. Unless the nature and extent of parental neglect reaches the point where a court will intervene, there is no power as such to require the treatment of a child. This is often a source of anguish to school people in those cases where the child's difficulties are related to emotional problems of a parent in a way that leads the parents to refuse to take action.

How about special classes in schools?

School systems, of course, do have the authority to place children in special classes.

Most school systems have departments of "special education." These

usually maintain classes for various types of handicapped children. In some instances there may also be special classes for gifted children as well. Among the types of handicap for which it is customary to maintain separate classes are: serious mental deficit, low vitality, deafness, blindness, and "social maladjustment."

Do schools maintain special classes for emotionally disturbed children?

Very few school systems now have special classes frankly recognized as such for emotionally troubled children. What happens in practice is that some children unable to function well in regular classrooms are smuggled into the existing special classes because the smaller size of the special classes and the greater tolerance that special education teachers often have for deviant conduct may be an asset to the child victim of mental illness. In some cases, the child's scores on intelligence tests may warrant placement in a class for slow-learning children. In some cases, the child's anxiety may be very fatiguing to him and may warrant placement in a so-called "open-window" class.

In the larger cities there are often classes for children with disciplinary problems. The term "socially maladjusted" is sometimes used to describe such young people. In general, such classes are composed largely of preadolescent or adolescent boys who are aggressive, if not delinquent. Although such classes may serve a useful function in providing education for the small minority of emotionally disturbed children who produce aggressive behavior symptoms, they are worse than useless as a resource for the many timid, withdrawn, or depressed boys and girls who compose the bulk of the emotionally disturbed population in our schools.

There is a small but apparently growing tendency to establish special classes for children who have neuropsychiatric disturbances of a nature to render it difficult for them to profit from education in regular classes. A few states have authorized schools to establish such classes. There has been experimentation on such matters as size, composition, and program. Although the bulk of classes for emotionally disturbed children are maintained by mental hospitals, by youth treatment centers, and by private organizations, there are now a few within the context of regular public school systems.

What can be expected from such special classes?

Whether or not public schools should establish such classes is a matter of debate among professional educators. Not only is the question of cost of some concern, but there is uncertainty as to what useful func-

tion such classes can serve. Accentuating the doubts is the fact that among people in special education serious question has been raised as to the merits of segregating handicapped children. Many feel that the movement toward special classes has gone too far. They feel that many handicapped children are better off if they can be helped to make an adjustment to normal group living and that it is an important element in the education of normal children to learn how to help and how to cope with the problems of handicapped classmates. Such considerations give point to asking what special classes for emotionally disturbed children can hope to accomplish.

The parents of many emotionally disturbed children, especially those parents who have banded together in organizations, have tended to campaign for special classes because they believe that unless such classes exist their children may have to be institutionalized—and few states have adequate institutional facilities. Moreover, if the child is in a special class, the necessary treatment may be given while the child remains in his home.

In other cases it is felt that the presence of emotionally disturbed children in a classroom may handicap the teacher or otherwise distract from the efficiency of the classroom for the remaining children; therefore, the special classes may be an asset not only for the children placed in them, but also for the remainder of the school.

In the pilot ventures with such classes another factor has emerged. For some children the weight of emotional difficulties gives rise to what appears to be hopeless cycles of social difficulties with teachers or classmates or to more and more serious academic failures. In a special class of small size with a teacher who knows how to help such children, many learn through successes in the protected setting how to overcome their problems. With renewed confidence and increased ability, after a period of several months they can be returned to regular classes and make a good adjustment. If, in addition to placement in a special class, psychotherapy is given, the combined measures may be very advantageous.

Judging by all indices it would appear that during the next few years there will be considerable experimentation with various uses of such classes.

What training should be required of teachers of special classes for emotionally disturbed children?

As yet no standard pattern for the preparation of such teachers has emerged. Very few colleges or universities have inaugurated suit-

able curricula. One of the serious problems is that there are so few classes of this type in existence that it is difficult to arrange for adequate student teaching or internships. Most of the teachers in this field have had their student teaching either in the classes which mental hospitals give for their patients or in the classes for "socially maladjusted" children. On the academic side, the preparation, in addition to that required of all teachers, usually requires additional classes in mental hygiene, abnormal psychology, child development, and special education.

THE SENILE PSYCHOSES

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What is senile psychosis?

The diagnostic term *senile psychosis* is not in official use, but physicians sometimes use it as a synonym for *senile dementia*—the disease properly known as “chronic brain syndrome associated with senile brain disease.” In broader usage, the term *senile psychosis* or the *senile psychoses* sometimes refers to all psychotic reactions occurring commonly in old age, especially psychotic reactions associated with *cerebral arteriosclerosis* (hardening of the arteries of the brain).

What are the disorders known as the senile psychoses?

The disorders discussed here are limited to psychotic reactions that are more frequent in the latter years of life, are believed to be the result of physical (organic) changes within the brain, and often create serious social or economic problems. Such diseases are officially designated as “disorders caused by or associated with impairment of brain tissue function.” They can be acute—that is, reversible—or chronic (permanent). In the latter category, the two mental diseases of major importance are (1) senile dementia, the chronic brain disorder associated with senile brain disease, and (2) chronic brain disorders resulting from circulatory disease (disease pertaining to blood circulation), particularly cerebral arteriosclerosis.

How many individuals in the United States today are afflicted with the senile psychoses? How many are women? How many are men? Are these conditions becoming more common? If so, why?

Approximately 13 per cent (91,000) of the 700,000 patients in hospitals for mental disease in this country are victims of senile brain disease, cerebral arteriosclerosis, or some other circulatory disturbance affecting the brain. In addition, there are an estimated 700,000 people afflicted with these diseases who are not hospitalized. Although the relative proportion of males and females is not known, the majority

of these people are men—probably because vascular disease (disease of the blood vessels) is more common in men.

The number of people afflicted with the senile psychoses is definitely increasing. Thirty-five to forty per cent of all patients admitted to mental hospitals for the first time are over the age of sixty. Of the persons over this age who remain in the community, it appears that a small percentage can be considered psychotic. Others have less severe mental disturbances, but these, also, contribute to a serious medical and social problem. This problem probably results from the increase in the number of people living to old age rather than from an actual rise in the percentage of mental derangements among our elderly population.

How many of the patients over sixty-five, hospitalized for mental disorders, are victims of the senile psychoses?

Approximately 12 per cent (84,000) of the total hospitalized mental population is suffering both from senile brain disease and cerebral arteriosclerosis and is over sixty-five years of age.

What percentage of persons over sixty-five who are admitted to mental hospitals are suffering from the senile psychoses?

Approximately 89 per cent of all first admissions of people over the age of sixty-five are suffering from the senile psychoses.

What percentage of persons afflicted with the senile psychoses have senile dementia? What percentage have cerebral arteriosclerosis?

According to 1957 statistics of the New York State hospitals, of 19,951 first admissions for all reasons, 16.2 per cent had senile brain disease and 23.9 per cent had cerebral arteriosclerosis. Thus 40 per cent of people afflicted with the senile psychoses have senile brain disease and 60 per cent have cerebral arteriosclerosis.

Do any of these disorders occur more frequently in one sex or in certain national or economic groups? If so, why?

Cerebral arteriosclerosis, the most prevalent of the various disorders included among the senile psychoses, is more common in men, by a ratio of about three to one. It appears that the female hormone provides some protection against the arteriosclerotic process. Senile brain disease, on the other hand, is more prevalent in women, the ratio being about two to one.

None of these disorders seems to bear any relation to nationality. It has been reported that the senile psychoses are more prevalent at lower socioeconomic levels, but this apparent increase in incidence may simply reflect the greater need for hospitalization created by inadequate home facilities.

What are the causes of the senile psychoses?

The senile psychoses due to circulatory disease are caused by diminution of the blood supply to the brain. This decreased blood supply may result from arteriosclerosis of the cerebral blood vessels, or from disease of the heart or kidneys. Hereditary and hormonal factors, as well as dietary intake, are believed to play a part in the production of arteriosclerosis.

The second major cause of the senile psychoses—senile brain disease—is not adequately understood at this time.

What methods are used to diagnose these disorders? Who is qualified to make such a diagnosis? Where might tests be obtained? Are there charges for these?

A thorough history and a physical examination by a physician are the first essential steps in diagnosing these disorders. In addition, specialized laboratory tests, as well as psychological tests, may be necessary to rule out other diseases which might mimic these disorders. County medical societies, family service agencies, and public welfare departments are able to refer people to the proper sources for these services. Charges depend on whether the services are obtained privately or through public agencies.

What are the physical and psychological characteristics of an individual who has a senile psychosis? Does a postmortem examination of the brain show anything to account for the person's symptoms?

The two major forms of the senile psychoses—senile brain disease and cerebral arteriosclerosis—have many common features. There is impairment of memory (particularly for recent events), judgment, and higher intellectual functioning. Occasionally the afflicted person is disoriented as to time, place, and person. The emotions are under poor control, and in many cases personality characteristics of long standing are grossly exaggerated. Deterioration of personal habits may occur. The poor judgment displayed by people afflicted with either of the senile psychoses may lead to difficulties, particularly in financial matters.

Individuals with cerebral arteriosclerosis, as a rule, do not show the profound physical and mental decay of the person with senile brain disease. Because overall physical deterioration is less pronounced, people with cerebral arteriosclerosis are less likely to sustain fractures of bones. If they are bedridden, it is usually because of heart failure or a specific neurological deficit such as paralysis from a stroke. Individuals with cerebral arteriosclerosis are more often subject to headaches, dizziness, fainting attacks, and convulsions than are persons with senile brain disease. The memory defect of the arteriosclerotic person tends to be spotty and to fluctuate with time, as does the general course of his disease.

The person with senile brain disease, on the other hand, has a more diffuse memory defect that tends to become progressively worse as his general condition steadily deteriorates. Alterations in moral standards and sexual indiscretions are more likely to occur in senile brain disease, and paranoid reactions are more frequent. Senile brain disease is also accompanied by evidences of exaggerated aging of the entire body: general wasting of muscles, shrinkage of the soft tissue, loss of elasticity in the skin, thinning and graying of the hair, and easy fatigability. The gait is unsteady, and speech disturbances are common.

A postmortem examination of the arteriosclerotic brain shows softening in localized areas where tissue has been destroyed by the formation of plaques (patches) in the walls of the blood vessels supplying these areas.

In senile brain disease, on the other hand, the characteristic findings at autopsy are shrinkage of the cerebral cortex and a fibrous thickening of one of the coverings of the brain.

What are the earliest symptoms of the two major types of the senile psychoses?

About 50 per cent of the cases of cerebral arteriosclerosis are characterized by the sudden onset of a delirious reaction manifested by confusion, incoherence, and restlessness. In most cases this reaction gradually subsides, leaving the person at a reduced level of function. In the remaining cases, the onset is gradual, and the first symptoms are related to impairment of the intellectual processes of memory and judgment.

Senile brain disease has a gradual onset and a progressive course. In about half of those afflicted the picture is simply one of deteriora-

tion, affecting first the intellectual processes of memory and judgment. As long as no dramatic events occur to create serious disturbances in the family or community, many of these people are not brought to the hospital until they have reached an advanced stage of the illness. In the remaining cases, however, secondary symptoms such as depression, agitation, or paranoia can become major and extremely difficult problems. These symptoms are believed to result from the emergence of deep-seated and long-standing personality difficulties which have been released by the organic deterioration.

Can the individual afflicted with a senile psychosis ever be dangerous to himself or to others?

Yes. A person afflicted with a senile psychosis is dangerous chiefly to himself. His generalized confusion and poor judgment may lead to serious malnutrition and disease. His extreme emotional instability and poor control over his impulses may also make him dangerous to others. The smallest stimulus may cause a major reaction, and insignificant actions often appear as gross threats to the person with a senile psychosis. With proper care and supervision, however, many of these dangers can be minimized.

What is the effect on the family when a member is afflicted with a senile psychosis?

The answer to this question depends on the family and on the symptoms presented by the afflicted person. If the disease process is a mild one and the family resources—financial, physical, and emotional—are adequate, the effect is minimal. When the disease is severe and the resources are inadequate, however, the family may feel extremely burdened, angry, and guilty.

What effect does the family environment have on the afflicted member?

The answer to this question again depends on the family and the nature of the disease process. At times, the afflicted member perceives the underlying feelings of the family and reacts to them. In cases where the family feels hostility or guilt, the afflicted person may react with feelings of paranoia or depression. If, on the other hand, the family can treat the afflicted person with genuine respect, the environment will usually have a favorable effect on his reaction to the disease process.

What are the attitudes of the community, the family, and the afflicted person himself toward the senile psychoses?

In many cases of the senile psychoses the reactions of the community, the family, and the afflicted person himself are extremely negative. The older person is felt to be a useless burden, and may even be treated with open hostility by younger individuals. These attitudes obviously block improvement of the afflicted person, especially if his disease process is mild. A much-needed program to change these attitudes by educating the public concerning the abilities and special merits of older people is now being carried on by various mental health organizations.

The word "senile" is often used to describe an aging individual in a disparaging way. What does the term mean to the layman and to the professional person?

Although the word *senile* originally meant "old," it is often used now both by laymen and professional people, to refer to the infirmities or the deterioration sometimes associated with aging. It carries the connotation of weakness, infirmity, and hopelessness. Although it is a scientific fact that brain tissue that has been destroyed cannot be regenerated, it is incorrect to consider a senile psychosis as a "hopeless" condition. In many cases the most troublesome symptoms result from the individual's reaction to his awareness of senile changes. Certainly the use of the term *senile* should be avoided in talking to the afflicted person; and the families of such patients, as well as the general public, should be reeducated to a more optimistic concept of old age in general.

When might it be best for all concerned to have the afflicted member removed from the family environment? How is this decision reached?

This is an individual problem and is usually decided by the family concerned, with the help of the family doctor or a family service agency. As a rule, the decision is based on the resources of the family and the severity of the disease in the afflicted person. Nursing homes and institutions for the treatment of mental disease are available to care for these people.

Does hospitalization have an adverse effect on the individual with a senile psychosis? If so, why? What can be done to prevent this?

Hospitalization can have an adverse effect when the afflicted person thinks it is the result of the family's lack of interest or that it is a

punishment. To prevent this reaction, and to help prepare the old person for hospitalization, the institution should be described as an environment where he will be under less stress, will have fewer demands placed upon him, and will be with people who have similar problems and needs.

What treatments are available for the senile psychoses?

In general, treatment consists of providing adequate nutrition, controlling the exaggerated emotional states by means of drugs and somatic (body) therapies, and—of primary importance—establishing an environment where the afflicted person is made to feel capable, useful, and worthwhile.

Can the senile psychoses be cured?

The senile psychoses cannot be cured. Much can be done, however, to retard the organic process of brain damage, to alleviate secondary symptoms, and to engender the psychological attitudes which will foster the patient's comfort and happiness.

Can the senile psychoses be prevented? If so, how?

There is no known method of preventing the senile psychoses at the present time. Research now being conducted on both the arteriosclerotic process and senile brain disease may lead to specific preventive measures in the future.

Will all aging persons eventually experience some senile psychoses?

All persons will experience some effects of the aging process. Where the line is drawn and the person labeled "sick" is rather arbitrary. Strictly speaking, a person with a senile psychosis exhibits demonstrable impairment of orientation, memory, intellectual functioning, judgment, and emotional instability. Some or all of these symptoms may be present. If the senile psychoses are diagnosed strictly by these symptoms, then not all aging persons will experience the senile psychoses.

If senile dementia is caught at an early enough stage, can the illness be held in check or the secondary stages be prevented? If so, what signs might indicate the beginnings of the disorder?

Since the primary cause of senile dementia is unknown, the illness itself cannot be held in check. However, contributing factors such as

inadequate nutrition and poor general state of health may be improved. Also, work with the family and the patient might be expected to prevent many of the problems arising from the primary disease process. The beginnings of the disorder are usually characterized by disturbance of memory and judgment.

What agencies, institutions, or programs in the community are specifically concerned with the problems of the senile psychoses?

County medical societies, family service agencies, mental health clinics, and public welfare departments can all be helpful in dealing with the problems of the senile psychoses. Recently, more physicians have been specializing in the field of geriatrics (subdivision of medicine that treats all problems of old age and its diseases), and more psychiatrists, internists, psychologists, and social workers have become particularly interested in the problems created by the senile psychoses, both for the individual and for the family. Although the number of people working in this field is far from adequate at the present time, various communities have begun programs to provide institutional and outpatient care for these people. It is expected that the number of such programs will increase in the future.

SENSORY ISOLATION

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What is sensory isolation?

"Sensory isolation" is a term used to describe situations in which a person is more or less cut off from the usual sensations arising from the environment. The result is an unusual or abnormal restriction on the amount of information received by the waking brain.

How is sensory isolation produced?

In the early 1950's, experiments in sensory isolation were begun at McGill University by Donald O. Hebb and his associates. First they studied the effects, on animals, of being raised in isolation. Having found that dogs brought up from puppyhood completely without contact with any other living creature were in many ways abnormal, the scientists began some experiments with human volunteers. These studies served as models for subsequent research on sensory isolation. Human volunteers spent periods up to twenty-four hours or longer in a soundproof room. They wore goggles of milk glass permitting the discrimination of light but not of any objects. Their hands were encased in heavy gloves and the sense of touch was further restricted by cardboard cylinders extending from just below the elbows to beyond the tips of the fingers. In this way the usual sensations of vision, hearing, and touch were greatly reduced. Over periods of time ranging from hours to days, a number of Hebb's isolated subjects reported strange bodily sensations, visions (hallucinations), mental confusion, and dreamlike experiences while awake.

Since then many other scientists have produced various degrees of sensory isolation. One method involves prolonged enclosure in an iron lung. Another requires a subject to recline in an absolutely soundproof (anechoic, or echoless) chamber in total darkness. Still another essentially provides a protracted dark, quiet, dungeon existence. The most profound degree of sensory isolation, and the most extended series of experiments, have been carried out by Jay T. Shurley at the University of Oklahoma Medical Center. Shurley's subjects are suspended in a

tank of water at body temperature in a totally dark, soundproof, vibration-free room. There is virtually no sensory input in the fields of vision, heat, cold, touch, deep sensibility, pain, taste, or odor, and practically none in hearing. Under these circumstances a human being is more profoundly cut off from his environment than under any other yet devised on this planet.

What are the effects of sensory isolation?

It now appears clear that the effects of sensory isolation, as such, must be differentiated from *social* isolation, which nearly always contributes significantly to the picture. It also is clear that the experimental conditions make a great difference. For example, subjects isolated in an iron lung are helpless as well, and may suffer anxiety from feeling "trapped." In the "water tank" situation it is possible to standardize the experimental sensory isolation to a high degree. Commonly experienced by most subjects are all or some of the following: distortion of time sense; feelings of unreality; periodic dreamlike episodes suggesting a twilight state between sleeping and waking; occasional hallucinations of vision or, less commonly, hearing, or other senses; widely ranging and poorly organized thinking, which might be described as a spontaneous stream of free associations; and the emergence into consciousness of memories, fantasies, and other mental content not usually appreciated so clearly or vividly.

However, some workers in the field hold the view that many of the mental phenomena that appear under conditions of sensory deprivation are due more to suggestion and expectation than to the actual sensory deprivation.

Do people differ in their responses to sensory isolation?

Very much so. Some people find the experience exhilarating and stimulating. Apparently such individuals tolerate well the recognition of ideas which ordinarily are not conscious, and are highly self-dependent. Others find the sensory isolation situation very threatening and may become anxious or even panicky, demanding to leave the experimental situation within a very few hours or even minutes. Such individuals appear to be much more dependent upon their environment for psychological support, and less tolerant of their own emerging, previously unrecognized, mental content. Additional individual differences (relative to sex, age, cultural background, personality factors, etc.) are still under investigation.

What is the significance of such experiments?

Research on sensory isolation is important because it gives us another way to explore the unconscious mind. In the last half of the nineteenth century, the chief approach to exploring the unconscious mind was through the use of *hypnotism*. Toward the turn of the century and subsequently, a second method, *psychoanalysis*, was introduced by Sigmund Freud and his followers. This provided other techniques (verbal free associations and the interpretation of dreams) to arrive at an understanding of the unconscious mind. In the twentieth century the development of new *drugs* has made it possible to supplement these methods by a third, or chemical, approach. The intravenous administration of Sodium Amytal or Sodium Pentothal, so-called "truth serums," has proved to be of value in bringing out repressed thoughts and feelings. The treatment of combat neuroses by this method during World War II was termed "narcosynthesis."

Sensory isolation now provides a fourth technique (which may be used alone or in combination with any or all of the first three) for exploring the mysteries of the human mind which, like an iceberg floating in the sea, is largely concealed beneath the surface. Freud termed the process of thinking about reality, as we consciously understand it, "the secondary process," which might be considered a learned and civilized (i.e., highly human) form of thinking. The more primitive, largely unconscious, mentation he called the "primary process." Sensory isolation offers us new leverage in understanding primary process thinking.

Does sensory isolation cause a mental disturbance?

A better way of putting it might be to say that sensory isolation alters the balance of mental forces. Information coming in from the outside world, and from the body itself, apparently has an organizing effect on the personality; interfering with this tends to result in a certain amount of disorganization.

How can disorganizing a person be a useful thing to do?

Actually, it is important to be able to produce personality dysfunctions under controlled laboratory conditions in order to carry forward research on mental illness. Progress in medicine waited for centuries until men learned how to produce diseases in the laboratory. Only then was it possible to understand cause-and-effect relationships in the

development of many diseases. Such understanding led to dramatic advances in treatment and prevention. This deliberate production of disease for research purposes is sometimes called experimental pathology. Recently, the development of experimental psychopathology for research in mental health has evolved. Various methods are employed in order to produce an artificial mental illness in the laboratory.

Much of this work has been done with animals, but it always leaves something to be desired because of the uniquely human aspects of mental disease as we know it. *Human experimental psychopathology* might be said to consist of the development of the ways and means to produce artificial psychiatric disorders in normal people.

Dreams contain all the ingredients of mental illness: false beliefs (delusions); seeing and hearing things that aren't there (hallucinations); loss of contact with reality; strange bodily sensations; inappropriate emotions; etc. (See *Dreams*) These we regard as normal since they are experienced by everyone. But the mentally ill experience these phenomena while awake; their lives are something like waking dreams. It now appears possible to produce experimental dreamlike experiences in a normal waking person if two basic conditions of the nocturnal dream are brought about. These conditions are: (1) maintenance of capability for awareness (the sleeper dreams only when, periodically during the night, his sleep becomes so light that he is *capable* of being aware of something); and (2) sensory isolation (the sleeper is functionally isolated from his surroundings and is, to a great extent, unaware of what goes on around him).

Under these two conditions the sleeper becomes dimly or even clearly aware of the information in his own head—images, sounds, feelings, ideas—which are being “processed” constantly in a never-ending stream. Glimpses into this preconscious (unconscious material capable of emerging into consciousness) stream constitute the dream experience.

Certain drugs can produce these experiences (opium is a classic example), but most chemicals that impair sensory input also produce coma (general anesthesia). However, recently it has been possible to use drugs that poison the sensory system but stimulate alertness (for example, lysergic acid diethylamide, or L.S.D.) for experimental production of waking dreams. They can also occur as a result of exhaustion of the sensory system (such as occurs in prolonged sleep deprivation), hypnosis, brain stimulation experiments, and, finally, the laboratory type of sensory isolation by environmental manipulation with which this section is concerned.

Have there been practical results from research on sensory isolation?

Research enables us to predict certain things about personality and temperament. Possible applications of sensory isolation as a predicting technique are developing, particularly in the requirement for assignment of individuals to isolated tasks in the military services and in the space exploration program where prolonged social and sensory isolation (including decreased bodily sensations because of the weightless state) may be experienced by the astronaut.

How about purely medical applications?

Here, too, there have been some very helpful ideas generated by the sensory isolation experiments. The observation that primary process material comes more rapidly to the fore under these conditions has caused revision in certain clinical practices. Where it was once considered routine to isolate many delirious and schizophrenic patients who were badly out of contact with reality, it is now seen as more rational to bring them into situations where sufficient stimulation from the environment is available to help them maintain their already disrupted capabilities for reality-testing.

Other possibilities, including the use of the sensory isolation maneuver as a means of overcoming certain blocks or resistances in the psychotherapy of neurotic patients, are also being considered.

Finally, it can be anticipated that sensory isolation will prove to be an adjunct to certain diagnostic procedures, in which all extraneous influences and environmental distractions must be kept to a minimum.

What is the future of sensory isolation research?

As yet we know very little about the biological correlates of the subjective experiences reported by human beings in profound sensory isolation. At the time of this writing, techniques have been developed which permit measuring brain waves, galvanic skin response (psychogalvanic reflex), eye movements, and other biological changes that may take place while the experimental subject is isolated and floating under water, connected to the world only by his air hose. Such changes may well influence the mental changes that have already been discovered. There is reason to believe that many of these changes are *rhythmical* or *periodic*, and that various physical and psychological rhythms are interrelated with each other. Through the continuing use of sensory isolation as a research method, important progress in our understanding of these mind-body relationships can be expected.

SEX EDUCATION

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What is sex education?

The absence of a generally agreed upon definition of sex education is one of the causes of confusion about, and resistance to, sex education. To some people it means telling children about the process of human reproduction, including descriptions of the sexual organs of both sexes, and the processes of gestation and birth. Other people consider sex education to be all of the learning related to growing up as a boy or as a girl; the changes that take place in each sex during the growing up, and the ways these changes affect the relationship between boys and girls and men and women; the problems of dating, courtship, engagement, marriage, and possible ways of adjusting to or solving these problems.

Sex education is all of these, and more. For many persons, sex education is most importantly the transmission of feelings about their own sex and the opposite sex, and the way in which love affects the relationship. It includes aid in understanding sexual responses in both sexes and help in developing guides to behavior that is most likely to produce healthy personalities. Sex education, by these definitions, is an almost continuous process of nonverbal as well as verbal communication, at both the conscious and the unconscious levels.

Why is sex education so important to mental health?

Sex is so basic to personality and social interaction that every culture that has survived has found it necessary to control sex with elaborate social mores that are transmitted to children as guides to behavior. But in American culture, which glorifies romantic freedom to choose one's own mate—where torrid love scenes are movie and television fare for youngsters from the time they become interested, where youngsters from all classes are thrown together in our public high schools and colleges, where Sigmund Freud and Alfred Kinsey are misquoted by those desiring to create a new morality more suited to their own impulsive natures—there is great need for sound education

so that the young person may be helped to formulate his individual value system.

Many parents and educators now feel that the best approach to sex education is based upon a desire to help young people grow up with good feelings about being a boy or a girl, knowing about intercourse both as the means of human reproduction and, potentially, as the most beautiful and intimate expression of affection between a man and a woman who love each other. These parents and educators want young people to have good feelings toward the other sex, to have boy friends and girl friends at all ages, to "fall in love" and "out of love" a number of times before they "grow to love" a mature person with whom they desire to spend the rest of their lives in an intimate love-sex relationship involving children as well as each other. In American culture such a life seems most likely to lead to the personal fulfillment of each person—to a mentally healthy existence.

Who is responsible for the sex education of children and adolescents?

Every child gets a sex education while he is growing up. The important questions about this education are: What kind is it? From whom?

For better or worse, children are influenced most by the knowledge and attitudes of their parents and brothers and sisters. But all persons who work with children and adolescents are transmitting their knowledge and feelings about masculine and feminine roles and behavior. Many persons, because of their own attitudes or fears, are unconsciously teaching children that the sexual aspects of life are different somehow from the other aspects of life about which they may freely seek information and receive it. It would seem desirable, then, for all who work with children and adolescents to be able to help them gain healthy attitudes toward the sexual aspects of personality and human relations.

What knowledge is most important to the development of mentally healthy sex attitudes and behavior?

Knowledge about sex is important, but the way in which the knowledge is transmitted affects the development of attitudes more than the knowledge itself. Behavior is affected by both knowledge and attitudes.

It is important for the child to know that his parents know about sex and want to share this knowledge with him.

In the intimacy and natural nudity of family dressing, bathing, and toileting, the child observes sex differences. It is good to assure the child both of his own sex and the fact that this will not change. At about three years of age, the child is capable of wondering about his own existence, and is satisfied to know that he grew inside his mother until he was big enough to breathe and eat. Observance of the birth of an animal helps to broaden this concept.

At about five or six, the child wants to know how he came out of his mother and also about the role of father. Parents and others who work with children should be prepared with simple words to describe intercourse, both as a means of reproduction and as an expression of affection between a husband and wife.

As children approach adolescence, they need to be prepared for the changes that take place in their bodies, their feelings, and their relationships. Particularly, they need to understand that girls develop a year or two earlier than boys (at about thirteen) and will probably be more mature than boys in almost every way; that about the time the girls' adolescent growth spurt slows down, the boys' growth spurt will begin and will continue for a number of years after the girls' growth stops, resulting in boys being bigger, on the average, than girls. This knowledge seems especially significant for early developing girls and late developing boys in preventing them from having unwholesome feelings about their own femininity or masculinity.

During adolescence children need help in understanding that sexual feelings develop differently in the two sexes: in general, girls' sexual feelings develop later and are more generalized, while boys' sexual feelings develop earlier and are focused more on the genitals. They need help in understanding how these facts affect them if they engage in necking and petting, and how sexual feelings may be confused with love feelings, leading to hasty and unhappy marriages. They need help in discovering the differences between infatuation, physical attraction, and the mature love-sex feelings that form the basis of a successful marriage.

And finally, young people need help in preparing for the love-sex adjustments of marriage itself. They need to be prepared in the event that there is some disillusionment as the exciting pace of courtship and engagement slows down to the routine adjustments of married life, and they need information on how the many problems of married life may be approached with a give-and-take attitude and in a spirit of mature love. A knowledge of family planning is desirable if they are to

have time to learn to adjust to each other before they adjust to the arrival of children, and to be able to space and limit the number of children so that each child may have the opportunity to become an important person to his parents and to himself.

What are schools doing about sex education?

Some schools are very negative, teaching only that school is not a place to learn about sex. In some kindergartens, Sidonie Gruenberg's *The Wonderful Story of How You Were Born* is read to children. In some first or second grades, the film, *Human Beginnings*, is shown to both parents and children to encourage and help parents share their knowledge and feelings. Some schools show the film, *Molly Grows Up*, which is the story of menstruation, to both boys and girls in the fifth or sixth grades, and follow it with *Human Growth*, a film that presents a simple description of human reproduction. It is increasingly felt that children should be given this information before they enter junior high school, where youngsters are much more self-conscious and sex conscious than heretofore, and where sex is a much more common topic of conversation.

Some schools show *Molly Grows Up* to seventh grade girls, and *As Boys Grow* to the boys in their physical education classes. Dating behavior and special problems such as masturbation are brought up for group consideration. Dating problems continue to be a topic of continuing interest throughout the high school years, with many fine films available such as *Shy Guy*, *How Much Affection*, and *Early Marriage* to stimulate wholesome discussion. Fine textbooks make available to students the research findings pertaining to the relationship between courtship behavior and successful and unsuccessful marriage. Films such as *This Charming Couple*, *It Takes All Kinds*, *Choosing for Happiness*, *Marriage Today*, *The Meaning of Engagement*, *Jealousy*, and many others can form the basis for down-to-earth discussions of intelligent mate selection and marital adjustment. Teachers specially trained to work with this important and sometimes delicate material are essential if such programs are to succeed.

The San Diego City schools, under the guidance of G. Gage Wetherill, Director of Health Education, have developed a most comprehensive program. It involves the use, in the early grades, of many films depicting all types of plant and animal reproduction; a full-time nurse who lectures to, and answers questions of, all sixth graders; a man and a woman who spend all their time meeting with junior and senior high

school girls and boys in voluntary groups. The schools have the advantage of access to many books and films not available to the individual parent, and also the advantage that behavior is highly influenced by peers during the adolescent years. In addition, group discussions under competent leaders or teachers make a better case for moral behavior than discussions usually generated in unsupervised groups.

Why are some parents and some religious leaders opposed to sex education in the schools?

It is assumed that most resistance comes from people who fear that what is learned will include knowledge they feel to be harmful to their children. Probably most of all, they feel that knowledge and talk about sex will stimulate sexual desire and lead to sexual experimentation. Or, they may feel that sex education may include knowledge about such things as contraception, which may be contradictory to their religious beliefs or which might encourage sexual promiscuity.

Well-qualified teachers are certainly aware of the teachings of the major religions and know that they probably have members of many faiths in their classes. Consequently, they usually refer these children to their religious advisers for the answers to questions about which there are basic disagreements. Occasionally, a poorly trained or unwise teacher, or an overly fearful or neurotic parent, may create a situation that harms the whole program. Close cooperation with the leaders of the school parent-teacher association is recommended; their endorsement of the program helps to reassure other parents of its soundness. It is considered desirable to advise parents of any sex education planned for the school and to make other provisions for children whose parents do not approve, rather than to require written parental approval before a child may participate.

Is there any evidence to indicate that sex education in the schools either encourages or discourages sexual intimacy?

Experimental programs in Oregon and Wisconsin convinced many educators and public health workers that intensive sex education programs in those states led to significant reductions in illegitimate births, venereal disease, and juvenile sex crimes. I know of no research that points in the opposite direction. The continuation of the comprehensive San Diego program for more than a decade shows that a

sound program can develop and continue to deserve strong public support.

What are current attitudes about masturbation?

In no other area of sex behavior have such marked changes of attitude developed in recent decades as in attitudes toward masturbation. The old idea that masturbation caused insanity, feeble-mindedness, and sexual aggression is thoroughly discredited. Most psychiatrists and psychologists now agree that masturbation is harmful chiefly if it produces severe feelings of guilt, or if the accompanying fantasy is always promiscuous or homosexual. Few fear "excessive" masturbation unless it has compulsive neurotic aspects, in which case psychological help is indicated.

Some psychiatrists and psychologists now see masturbation as a harmless way to relieve adolescent sex tensions, and feel that fantasy projected imaginatively into a happy marital situation may even stimulate a healthy urge toward future marriage. Others want to suspend judgment on masturbation for the time being, neither condemning nor approving it.

Is premarital chastity a goal of sex education?

I know only a few persons who question the wisdom of continuing premarital chastity as a goal for youth (and it is interesting that none of them has adolescent daughters). Most sex educators agree with Sylvanus Duvall and other authors that there can be no other defensible goal. At the same time, they recognize that such a standard is not accepted by all classes and families in our society, particularly for boys. They know that premarital intercourse is not uncommon, and try to make people who have experienced it feel that their future happiness has not been jeopardized. Most sex educators, I believe, feel that we shall have happier marriages when there is less emphasis on sex *before* marriage, and more emphasis upon sex *in* marriage. Too much emphasis on sex before marriage is likely to mean too little concern for important psychological and sociological factors such as comparable educational and intellectual abilities and interests, as well as compatible family, economic, and religious backgrounds. In general, the test of time and the test of companionship are the most valid predictors of the growth of mature love-sex feelings that make for successful marriage.

SEXUAL DEVIATION

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What is a sexual deviate?

The term "sexual deviate" is the modern equivalent of "sexual pervert" or the older and unnecessarily harsh term, "sexual degenerate." In general, it refers to anyone whose sexual satisfaction is obtained from practices other than adult heterosexual intercourse. But this general definition is not adequate because masturbation is not classified as sexual deviation.

What are the types of sexual deviation?

The most prevalent and important type of sexual deviation is homosexuality: this refers to sexual relations between two adults of the same sex. Sexual contacts between male adolescents is also often classified as homosexual although it may not be followed by adult homosexuality. (See *Homosexuality*)

Child molesters or pedophiles are the next most significant type of sexual deviate. These are male persons who obtain gratification by palpating or sexually playing with minor female children, or having the children palpate them. Male persons who perform homosexual acts on male children also fall into this class. In the group of adult males who seek out boys, fellatio (sexual stimulation by oral contact) or mutual masturbation is the usual activity.

"Peeping Toms" or voyeurs are classed as sexual deviates if their gratification is obtained through the act of witnessing a woman disrobing or through sexual activity by others. Masturbation may accompany the viewing of sexual acts. The voyeur wishes to observe sex activity without being seen himself. This particular deviation is more frequent among youths or young men.

Exhibitionism consists of displaying the sexual organ to an unsuspecting member of the female sex. The exhibitionist wishes to surprise a woman or girl, chiefly at the time of an erection. This activity is accompanied by masturbation at the same time or soon after. The

psychological reaction of the one to whom the exhibition is made is watched closely by the exhibitor, and much of the exhibitionist's satisfaction results in this way.

Sadists (those who derive pleasure from inflicting physical or psychologic pain on others) and masochists (those who derive pleasure from suffering the pain themselves) are also classified as deviates. They are more likely to come to attention as a result of criminal activity or in the process of treatment of neurotics. The enjoyment of sexual satisfaction through sadistic activity is seen among psychopaths, whereas masochistic satisfaction is more common among neurotics. It should also be noted that many of these impulses that are called "deviations," form "part impulses" of normal heterosexuality. Sigmund Freud was the first to call attention to the numerous sexual impulses in childhood that carry over into adult sexual intercourse, the so-called "polymorphous perverse" impulses. Some of these impulses are part of the fore-pleasure preceding normal sexual relations and are symbolically expressed in love play; for example, the phrase, "I could eat you," expressed in playful embrace, or "hurt me," in the throes of orgasm, or the seductive "vampire" (of an earlier generation) with its sado-masochistic overtones.

Fetishism is a type of deviation in which sexual gratification is derived not from a woman's body but from objects worn by a woman, such as shoes, underclothes, and stockings. Often masturbation is performed with the aid of the fetishistic object. Occasionally, fetishists employ symbols worn by males, as in a recent case where large numbers of cowboy boots were collected by a homosexual.

Transvestism (dressing up in clothes of the opposite sex) is accounted a deviation, even though it may occur on festive occasions such as a homosexual "drag" or party. Frottage, which consists of obtaining gratification from rubbing against clothed women, as in a subway crowd, is a type of deviation not seriously considered by the law, as is "goosing," which may form part of group play among adolescents and some youths, or may be a compulsive perversion.

The rarer types of deviation, bestiality (sexual relations with animals) and necrophilia (sexual relations with the dead), are encountered occasionally as are types of self-sadism such as whippings, bindings, and crushings inflicted for their sexual gratifications. Some persons classify pornography with sexual deviation, where its viewing replaces sexual acts of normal variety. And finally incest and rape should be mentioned because they are criminal acts but do not strictly fall among the groups

of sexual deviation. Sodomy (anal intercourse) is ordinarily one aspect of homosexual activity. The word is also used for sexual intercourse between a human and an animal.

What is a "hermaphrodite" or "morphadite"?

"Morphadite" is a corruption of "hermaphrodite," denoting an individual who has both male and female sexual organs. Actually, this is extremely rare in humans. Pseudohermaphroditism (an individual with congenitally malformed external genitalia resembling one sex, while the gonads are those of the opposite sex) is a more common condition. Such anomalies have no direct relation with homosexuality or deviation. Formerly, the term was loosely used to denote homosexuality or deviation, but obviously this was incorrect.

Is masturbation a deviation?

The answer to this question has much to do with social custom, culture ideals, religious and ethical attitudes, and life circumstances. Ordinarily, masturbation is considered a part of the normal psychosexual maturation process of young people—a type of exploration or experimentation. When it extends into adult life and precludes sexual intercourse in marriage or continues several times within twenty-four hours, or when it occurs where heterosexual partners are available, it is commonly considered as an aspect of sexual neurosis, or even mental illness. In modern psychiatry, masturbation is no longer considered a sexual deviation.

Are there female deviates?

Yes, but less commonly than male deviates. There are considerable numbers of Lesbians or overt female homosexuals, but they excite less public indignation and legal action than do male homosexuals. The more aggressive types of deviation—sadism, pedophilia, fetishism, bestiality, etc.—are seldom found among women, for obvious reasons.

Are there more deviates now than a generation ago?

It is difficult to obtain figures for such a comparison, but law enforcement officials and psychiatrists agree that there are more deviates at the present time. Some authorities feel that World War I and World War II stimulated the growth of homosexuality and other deviations. This opinion deserves comment.

There is no doubt that in the Western world from the 1920's the relaxation of sexual taboos and restrictions in the general population stimulated increased individual sexual expression. In fact, adoption of the term "deviation" as opposed to the term "degeneracy" indicates the changing of public attitudes, a shift from contempt to toleration toward sexual abnormalities. This reorientation permits homosexuals, for example, to express their preferences more openly.

Secondary factors in the greater sexual freedom of today's youth is the worldwide acceptance of sexuality as an integral part of a full life, and the lowering of restrictions on many of the activities of girls and women. This greater sexual freedom has provided an atmosphere in which sexual deviation, in persons so disposed, is more readily expressed. In other words, the world wars were not responsible for relaxation of sexual restrictions, but the "sexual revolution" that began just after World War I allowed open expression of sexual impulses of many types. On the other hand, certain deviations, for example, homosexuality, pedophilia, and sadism, have always been represented in civilized life from the days of the ancient civilizations.

This writer, however, agrees with the opinion that there is a proportionate increase of active homosexuals and deviates today compared with the first three decades of this century.

What are the psychological characteristics of the deviate?

As with all questions of this type, no specific answer can be given. Homosexuals need not necessarily be effeminate in their attitude, dress, or demeanor; many homosexuals are athletic, virile-looking men with no trace of femininity in their manners.

Psychological characteristics of pedophiles or exhibitionists vary widely.

Perhaps the only comprehensive statement to be made is that sexual neurosis with deep unconscious conflicts (hostility toward women, fear of women, narcissistic oversatisfaction in their own genitals, fear of injury to the genitals) generally characterize this group. Among transvestites, identification with the female constitutes psychological motivation. Concerning sadism, masochism, fetishism, and the like, only the individual case can, after prolonged study, provide the answer to the basic psychology involved.

In general, one cannot identify a deviate from his appearance or speech.

Is sexual deviation an inborn characteristic?

Medical opinion has swung sharply away from the notion that homosexuality depends on an organic component present at birth. Such cases as derive from a hormonal (glandular) distortion are extremely rare.

Chiefly, homosexuality develops as a psychological defense against enormous (unconscious) fear of women with subsequent retreat to men for sexual expression.

In relation to other types of deviates, the mechanism of deviation serves to erase or minimize the unconscious fear lurking beneath the surface. For example, the exhibitionist, by his display, strives to overcome his strong inferiority feeling, either about his genitals or the meaning of his whole life; the fetishist develops a fixation on an article of female attire as a defense against fear of expressing his sexual desires directly. And finally, it should be stated that many deviates are so fixed in their pattern of life interests and sexual expression as to cause it to appear to have been congenital in origin.

Is there any relation between sexual deviation and intelligence?

The intellectual levels of sexual deviates run entirely parallel to that of the general population. Studies in hospitals and penal institutions fail to reveal any distinctive intellectual level. It is true that pedophiles give the clinical impression of mental dullness, but often this is due to the emotional flatness prevalent in these individuals.

Are all sexual deviates potential criminals?

A crime is an act that is forbidden by statutory law. Therefore, to answer this question, one would have to read the penal codes of the various states and examine their definitions of sexual crime. Since most of the law codes include as crimes any sexual practices other than those sanctioned in marriage, the answer would be in the positive. Although statutes vary greatly such crimes as rape, incest, sodomy, carnally abusing a child, rape-murder (sadistic acts), and mayhem are uniformly considered felonies. Other offenses, such as exhibitionism, voyeurism, frottage, etc., are often listed as misdemeanors or violations of various municipal codes. Of course, many types of sex crimes are reported only rarely.

It is obvious from the foregoing that all sexual deviates are potential criminal offenders. This statement, however, must be tempered with recognition of the handling of the problem; for example, in many

localities homosexuality is overlooked, although listed as a crime in the penal codes or local ordinances of the states or municipalities involved. It must also be stated that normal sex relations under special circumstances, such as adultery or fornication—in some jurisdictions denoted as crimes—are occasionally cited as offenses. Another exception to the rule that sexual deviates are potential criminal offenders occurs with regard to transvestites, who are usually considered to be harmless nuisances.

Is "sexual psychopath" the same as "sexual deviate"?

The subject of sexual abnormalities, as far as psychiatry is concerned, is not a static thing and definitions are not universally agreed upon. For one thing, public attitudes toward sexual deviates, and necessarily psychiatric attitudes also, have been changing rapidly. Further, the law subtly modifies psychiatric thinking in this area, inasmuch as the courts call upon psychiatrists to assist in the practical task of dealing with this group of offenders.

With this in mind, it can be said that the term "sexual psychopath" is a legal one essentially, and the term "sexual deviate" is a medical one. Originally, the former was a medical concept, the sexual psychopath being one type of the general diagnosis, "psychopathic personality." The notion of a fixed distortion of the personality in a given direction is central to the psychopathic personality concept; hence, in this sense, the sexual deviate is a "sexual psychopath" if his deviation is fixed in his personality structure. However, the question of fixity of deviation in the personality is itself a debated question.

Many states have passed laws that attempt to isolate the sexual case from the general criminal population in their institutions. To do this, a detailed definition must be set up. Such a one is that of the state of California (whose laws follow those of New York State, in the main, and are similar to those of other states throughout the country). In the California code, a "sexual psychopath" is defined as one "who is affected in a form predisposing to the commission of sexual offenses and in a degree constituting him a menace to the health or safety of others." Further characteristics of this legal definition are that he involves

"a child under the age of fourteen in a sexual act . . . or has had a previous sexual offense . . . or (as listed in the codes of Wisconsin, Illinois, and other states) has uncontrollable impulses toward abnormal sexual acts."

A report from a committee of the Group for the Advancement of Psychiatry states:

"A sexual psychopath . . . is guilty of repetitive, compulsive acts . . . carried out to the point of community intolerance . . . manifesting a heedless disregard of consequences . . . seeking to attain ultimate expression even if momentary obstacles are encountered."

In most jurisdictions, after a petition or complaint concerning the sexual psychopathy of an offender is filed, the diagnosis is made by two or three psychiatrists appointed by the court.

"Sexual psychopath," then, is a legally circumscribed term, but its diagnosis is determined by experienced psychiatrists. In addition, reports of probation officers and social workers are presented to the court, which makes the final pronouncement of the presence or absence of sexual psychopathy in a given offender. Often (as in California) the superintendent of the state hospital to which the offender is committed submits a final opinion concerning the psychopathy of the offender to the judge. From this brief sketch of the legal process, it can be seen how careful the courts are in the designation of a sexual deviate as a sexual psychopath.

The chief purpose of designating a subject as a sexual psychopath is to attempt to segregate him from the main body of criminal offenders in penal institutions or state hospitals. Equally important aims are to institute treatment for the psychopath and to remove him from society until he is cured or his condition is ameliorated. (See *Sexual Psychopaths and the Law; Psychopath or Sociopath*)

What kinds of treatment are there for the sexual deviate?

The main work of treatment of deviates convicted of criminal offense is done in institutions. This work has been done chiefly since World War II. In general the treatment accents group therapy, individual counseling, and perhaps occasionally, psychoanalysis of the offender. In these techniques, main reliance is placed on giving the offender an opportunity to examine his motivations, to ventilate his feelings about sex, and openly to appraise the sexual maladjustment he has made. Often the therapist tries to find in the early life of the offender influences that may have impelled him into deviation. Therapists in some institutions attempt to delve more deeply into the unconscious determinants of the offender's psychological background. Other therapists are content to attempt to socialize the offender, to increase

his control mechanisms, and to offer and urge the use of other channels, such as work or education, for the purpose of sublimating his drives.

In addition, there have been more drastic nonpsychological methods of treatment proposed for the sexual deviate; among these are surgical operations to castrate the offender, hormone injections to minimize or alter the sexual drive, and various treatments used on mentally ill persons, such as electroshock therapy, etc. In the main, these measures have been abandoned, particularly castration—although it still has its adherents—chiefly on the ground that surgery will not reduce the drive itself, no matter how it modifies the sexual organs. In fact, many experts feel that surgery will increase the sex drive, partly out of frustration, and may even result in increased aggressive acts.

Among those deviates who do not come to the courts but who appeal to private psychiatrists or clinics for help, the treatment is much the same as that of institutions and hospitals. Perhaps in private practice and clinics more attention is paid to the psychological soil from which the deviate has sprung. Often, psychoanalysis is employed in an attempt to change the identifications of the patient or to treat underlying neuroses that may be responsible for the deviation.

Are such cases cured by treatment?

This is a moot question even among professional workers in the field. Most psychiatrists have successes among their cases and all have had at least some failures. It is not always easy to foretell which emotional factor in individual treatment is responsible for improvement among deviates. Among youthful deviates, the development of a transference (unconscious attachment to others of feelings and attitudes that were originally associated with important figures in one's early life) to the therapist, or relief of inferiority feelings, or removal of (unconscious) fears, may result in improvement. In general, the younger the deviate when he applies for treatment, the better the results. Another factor has application here: the wish of the patient to be treated is vital to the success of the undertaking.

Treatment is usually difficult and prolonged, depending in part on the patience and perseverance of the therapist and on a revamped social environment into which the patient is placed after treatment. It is worth noting that women therapists often have good results with male deviates because of the warm maternal atmosphere they provide. In this regard, adolescents of both sexes who show sexual deviation present a good outlook if treatment is administered by a well-balanced

therapist who has a good grasp of the psychology of youth and its special emotional problems, and who is conversant with the peculiarities of emotional immaturity among youth.

Are prostitutes classed as sexual deviates?

Formerly, psychiatrists and sociologists described prostitutes as psychopathic personalities of the inadequate type or as mentally dull individuals, but this is an unrealistic classification. It is true that prostitutes do engage in this activity in reaction to deep-seated neurotic conflicts, particularly hostility toward men and a schizoid cleavage between love and sexuality. Further, some psychiatrists think that prostitution represents a "regressed" sexual development, related to neurotic (unconscious) conflicts toward giving men emotional release, i.e., they "deny" men love. Many such women are actually frigid or are able to suppress their sexual feelings automatically when they are with their clients.

However, it would be naïve to say that these mechanisms motivate the majority of prostitutes. Chiefly, the motivation is economic. A second factor is the ego-syntonic nature (that is, the congeniality) of a semi-underworld life and a certain camaraderie among women of that group, which provides emotional security to many prostitutes, perhaps unconsciously.

The cultural setting of many countries wherein the attitude of women toward men is less equalitarian than in the United States also tends to diminish any suspicion of sexual deviation among these women. Although it is true that some prostitutes perform deviated acts for their patrons, this usually occurs in response to demands of deviated or neurotic clients. In general then, from a psychiatric point of view, prostitutes cannot be classified as sexual deviates.

Can sexual deviation be prevented?

This question cannot be answered in a categorical way. Mental hygiene influences, education, and psychotherapy may have some effect in reducing sexual deviation. Nevertheless, it is not possible to state that these activities really do prevent the development of deviation. Certainly among the young, proper identification with normal, mentally healthy parents or parent substitutes, in schools, churches, and social organizations will do much to reduce deviation in adolescence. An atmosphere that is neither too restrictive nor too permissive is

essential for the healthy sexual development of the child. Among older persons, sexual deprivation may be a factor, or a disharmonious marriage may occasion the rise of neurosis, which may result in "acted out" behavior. Mainly, however, the enormous area of neurosis, the imbalance of aggressive and passive factors in the individual personality, and the lack of gratification gained from ordinary pursuits and arrangements in life, all constitute the base line from which deviation emerges. To expect that these unpredictable factors can be singled out and combated in an attempt to prevent the deviation that develops in a large number of people would be unreasonable.

Perhaps the greatest factors in preventing sexual deviation would be an alert citizenry, respectful of psychotherapy in its various forms, ready to urge patients toward help as early as possible, and a mobile educational system aware of emotional problems in children when they first appear.

SEXUAL PSYCHOPATHS AND THE LAW

by HENRY WEIHOFEN

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Not only psychiatrists but also many members of the public have come to recognize that there are persons of abnormal emotional drive who cannot be deterred by the threat of punishment or reformed by its infliction. Most of these persons are probably not so seriously disordered that they can be committed as "insane" under the legal test of insanity absolving one of responsibility for crime. But holding them responsible and punishable has seemed inadequate too, because prison terms for some of the conduct the public has been concerned about are too short to protect society against more dangerous acts that such persons (it is feared) may commit in the future. Sex offenders have commonly been thought to present this danger in a specially acute form. This has led, since about 1938, to the enactment of what are generally called "sexual psychopath" laws.

The reasoning behind these laws is that since the persons they are aimed at are not so "insane" that they can be committed as criminally irresponsible, and since they are apparently incorrigible and are not deterred by prison sentences, we need a procedure by which they can be "treated" and cured, and society meanwhile can be protected by keeping them securely confined until they are cured and safe to be at large. Whether the laws succeed in this purpose is another question.

These laws generally are aimed at persons whose antisocial behavior is motivated by sexual deviation. "Sexual psychopath" is the term most commonly used. But while this sounds like a medical term, psychiatrists are not agreed on what it embraces. "Psychopath" has been called a "wastebasket" category into which it is common practice to throw together various abnormal types who do not fit into the categories of psychosis, neurosis, or intellectual deficiency. The psychiatric profession has given up the term "psychopathy" in favor of "sociopathic personality disturbance." Insofar as it is possible to generalize, we can say that persons so labeled do not typically exhibit mood dis-

turbances; they have no delusions or hallucinations; they are not intellectually subnormal. Yet they show a repetitive pattern of abnormal, often antisocial, behavior. Some anomaly in their emotional, moral, or sexual makeup seems to prevent them from making good social adjustments. They seem incapable of putting themselves into the other person's position or to feel any concern for others' rights or feelings. Their early years often were spent in impoverished, embittered, and unloving surroundings, and it is this perhaps that has left them unable to develop warm personal relations with other human beings.

Legislative definitions vary considerably. A survey by the American Bar Foundation in 1961, "The Mentally Disabled and the Law," said, "Although some twenty-seven jurisdictions purport to deal with the same personality in their sex deviate laws, there are twenty-eight different definitions or descriptions of that personality." A number of the laws speak in terms of mental disorder rendering one unable to control one's sexual acts or perversions, or of a "propensity to commit sex offenses." Some use phrases such as "marked departure from normal personality," "utter lack of power to control his sexual impulses," or "sexual act of a compulsive or repetitive nature."

Some of the acts are expressly made applicable to mentally defective persons as well as to psychopaths. But more often "feeble-minded" persons are specifically excluded from the acts' operation. So are "insane" persons. Typical language is "suffering from a mental disorder and is not insane or feeble-minded." But the acts do not define either of these words. And since there is no black-and-white distinction between "sane" and "insane," or between "psychopathic" and "insane," but only a continuum of gradations from the one extreme to the other, deciding who comes within the act and who does not is administratively difficult.

Even if it can be determined that a person is "mentally disordered" within the meaning of the sexual psychopath law, it may be difficult to decide whether he is not therefore also "insane" within the meaning of conflicting or overlapping provisions of the ordinary law providing for commitment of the "insane." Probably a substantial number of the men committed under the law are seriously enough disordered that they should be considered "insane," if by insane we mean suffering from a major psychosis. At the other extreme, distinguishing between deviate and normal sexual behavior may also be difficult. Does rape of a mature woman indicate sexual deviation, or merely failure to control

normal sex impulses? Even sex practices formerly considered highly irregular have more recently been shown by psychiatric and sociological investigations to be so prevalent that they must be considered to be within the limits of normal behavior.

Psychiatry has learned that crimes not overtly sexual may, nevertheless, sometimes be sexually motivated. Kleptomania and pyromania are well-known examples: some persons derive sexual gratification from the act of stealing, or from setting a fire. Burglaries and "Jack-the-Ripper" stabbings are other examples. To cover such instances, some of the statutes (California, Connecticut, Maryland, Ohio, Vermont, Virginia, and Wisconsin) apply not only to overt sexual crimes but to any offense in which sexual deviation appears to have been an element. (See *Sexual Deviation*)

The older-type laws use a noncriminal commitment procedure. Others also provide a civil procedure, but apply only to persons who have been charged with a sex crime.

Unlike ordinary hospitalization laws, which permit proceedings to be initiated by members of the family or others, these laws typically allow only the prosecuting attorney to initiate action. If the prosecutor has reasonable grounds to believe that a person charged with crime is a "sexual psychopath" within the meaning of the law, he may ask the court to suspend the criminal trial until the issue of sexual psychopathy is decided. In some states the court may initiate such proceedings on its own motion. (See *Hospitalization*)

Before the hearing, the person is examined by two or more physicians, usually psychiatrists. In some states, the examination is at the state hospital or other institution and the law permits the person to be held there for observation for a period usually limited to thirty or sixty days (ninety days in the states of Washington and Pennsylvania). The person is usually allowed to have a psychiatrist of his own choosing examine him at the state's expense. The examination reports may be very brief—sometimes they contain hardly anything more than a statement that the doctor has examined the person and has found him to be a sexual psychopath within the meaning of the act. Such a report is more a legal conclusion than the law should be applied than it is a medical diagnosis.

The medical report is submitted to a court, which then holds a hearing to determine whether the person should be committed as a sexual psychopath. This is a judicial hearing, at which the person is of course allowed to have counsel, although only a few states provide

for the appointment of counsel to represent persons who cannot afford to retain their own. Under most of these laws, the person may demand a jury hearing. In some states, either party may demand a jury. Only Indiana and New Hampshire specifically deny any right to a jury.

To avoid having to apply the loose norms of the older types of statutes, most of the more recent statutes restrict application of their provisions to persons who have been convicted of crime. After conviction but before sentence is imposed, the trial judge is required to have the defendant examined psychiatrically; only after he has received the psychiatric report does the judge decide whether the defendant should be sent to prison or to a mental institution. This sacrifices a certain amount of social protection in favor of personal liberty. It would be socially desirable to apprehend and commit the potential sex offender before he commits an offense, but trying to do so on the basis of vague constructs such as the older statutes employ opens the door to arbitrariness and abuse.

One major characteristic of all these older laws is that if a person is found to be a sexual psychopath, he may be committed indefinitely, until he recovers and it is safe to release him. In some of the newer-type statutes, however, that come into operation only after conviction for crime and before sentence (New Jersey, for example), the incarceration may not run longer than the maximum period for which the person could have been imprisoned for the crime. But in New York State it is wholly indeterminate, and may be from one day to life.

Under both types of statutes, the person is released only when the hospital certifies that he is cured or sufficiently improved so that he is no longer dangerous. The recommendation for release must be approved by the court. Often the release is conditional; the person is on a kind of parole for a period before being given a final discharge.

Under most of the older-type statutes, hospitalization for sexual psychopathy only postpones the criminal trial; upon discharge, it may be resumed. But even when permitted, resumption of criminal prosecution is difficult. If the person has been institutionalized for a long time, witnesses may have died or moved and resentment against the person will probably have cooled. Even if convicted, the court in passing sentence will probably take into consideration the fact that the person has already served a long time in an institution. In California, 86 per cent of the men returned to the criminal courts after treatment at Atascadero State Hospital are placed on probation, but the possibility of criminal prosecution and punishment hangs

over the person's head and may be a hindrance to his further improvement and cure. These considerations have led some states, such as Ohio, to provide that the period of hospitalization shall apply as time served on any sentence later imposed for the criminal act. Even this still leaves the person facing a criminal charge, and this is not conducive to cure. Other states, such as Michigan and New Hampshire, have, therefore, provided that commitment as a sexual psychopath disposes of the criminal charge.

Only California and Michigan have made much use of the statutes. California commits an average of more than 350 persons each year, Michigan about 60. In California a man who has never been charged with a sex crime but who is worried about his sexual adjustment may voluntarily ask a court to commit him to the hospital as a "mentally abnormal sex offender." Such a person cannot be held for more than two years. This offers help to men who recognize the nature of their problem and decide to seek treatment before they are charged with a serious crime.

Although the sexual psychopath laws were generally hailed as an enlightened step forward when they were first enacted, recent thoughtful opinion has been severely critical. Both medical and legal commentators have called the laws "crude," "ineffective," "too loosely drawn," and "undesirable in principle." Major criticisms were summarized in a 1961 report of the American Bar Foundation on "The Mentally Disabled and the Law." These are included in the following:

1) One basic assumption on which these laws almost invariably rest is that there has been an alarming increase in sex crimes. Typically, they have been passed as a result of public outrage aroused by a single sensational sex crime. The Michigan "Goodrich Act," for example, got its commonly used name from a man whose trial and conviction for a heinous sex crime touched off agitation for a law to "do something" about such cases. But statistics fail to demonstrate any clear trend toward more sex crimes.

2) Another cause of public alarm is the assumption that sex deviates are peculiarly dangerous. This assumption has also been challenged. Sex deviates are probably less dangerous than most other criminals. Most of them are not "oversexed," vicious, or aggressive, but are more usually submissive, passively dependent, and passively hostile characters. Alfred C. Kinsey, in a careful estimate, concluded that not more than 5 per cent of convicted sex offenders were dangerous persons likely to use violence or to injure anyone physically.

3) Another popular notion is that sex deviates tend to repeat their criminal acts more than other criminals. Here it is necessary to discriminate among several kinds of sex offenders. The "Peeping Tom" and the exhibitionist do tend to repeat, but they are more of a nuisance than a menace. Some child molesters also repeat their offenses, but most other kinds of sex offenders do not tend to be any more recidivistic than other criminals. They not only have a lower rate for second convictions than burglars, arsonists, and gangsters, for example, but also violate parole less frequently. Of those who do repeat, most commit a nonsexual crime. Only 7 per cent of those convicted of a serious sex crime are later again arrested for a sex crime.

4) Another common misconception is that sex offenders tend to graduate from committing less serious to more serious crimes. This is not true. The exhibitionist does not develop into a rapist; on the contrary, the peculiarity of his behavior lies in the fact that he satisfies his sexual urge by merely exhibiting himself. Any woman annoyed by such a person can safely walk up to his car (the exhibitionist today usually sits in an automobile) and copy down his license number. (It is probably evidence of the pathological nature of his behavior that the offender rarely makes any effort to hide the license number.) The habitual peeper is typically a timid, passive sort. Because he has his own peculiar outlet for sexual tension, he is probably less likely than most men to explode into violence or aggressive assault.

5) Since "sexual psychopath" is, as already said, a legal and not a medical classification, difficulties in delimiting the category are inevitable. The vagueness of the criteria has been decried not only by psychiatrists but also by legislative research committees, such as those of California, Illinois, and New Jersey. The lack of medical definiteness leads to wide variations and inconsistencies in interpretation among psychiatrists and judges. Studies of the operation of some of these laws have revealed no rational pattern of distinction between men sent to prison as normal sex criminals and those sent to the hospital as sexual psychopaths, either in the nature of the acts committed or in the record of recidivism.

Although the purpose of the statutes is to provide treatment for persons whose conduct seems to be the product of mental or emotional aberration rather than of "normal criminality," and who, therefore, may be helped by therapy, the law in practice sometimes operates

in almost the opposite way. In New York, for example, it is likely to be the untreatable, hardened offender whom the judges are most likely to send to Sing Sing as a sexual psychopath—not the man most likely to benefit from treatment, but the one least likely to benefit. The person who appears to be a good risk for rehabilitation is more likely to be charged and convicted of the crime and then placed on probation.

6) The statutes assume not only that we can define a class of persons as “sexual psychopaths” and recognize them on diagnosis, but that having found them, we can cure them. But the legislative definitions cover a miscellany of conditions about whose etiology, diagnosis, and treatment medical science is still largely in the dark. Legislatures that have responded to popular clamor for such laws have not usually been quick to appropriate funds to build, equip, and staff the institutions to do research and provide therapeutic programs. Even in the better hospitals, group psychotherapy is usually the only kind of psychiatric treatment available, and because of lack of personnel, patients must wait for weeks or months or even a year before they can be placed in a treatment group. Sending persons for whom medical science has no cure into the state hospitals and insisting that they be kept there until cured, would be to convert our hospitals into prisons, overcrowded with an accumulation of antisocial persons for whom the hospitals can offer little more than safekeeping. Probably only the lack of enforcement of these laws in most states has prevented this result from becoming acute.

7) The laws have been criticized as discriminatory, in that they are in practice applied only against men, not against women. Although prostitution would seem to come within the definition of most of these statutes, and although prostitution is by far the most common sex offense, these laws are never applied to prostitutes. This may evidence a recognition that the prostitute’s problem is more likely to be social and economic than psychological. Homosexuality occurs among women as well as among men, yet while homosexual conduct is the ground on which the laws are invoked against men in a high proportion of the cases, they are rarely if ever used against women. (See *Homosexuality*)

8) The sexual psychopath laws have been denounced for infringing on the tradition of our law that a person is not to be punished except for crime. These laws are not invoked because of any specific conduct; some conduct may have called the person to the authorities’ attention, but the issue in question is not whether he was “guilty” of that conduct, it is rather whether he is a sexual psychopath—not what he did,

but what he is. To determine whether a person is a sexual psychopath the examination may take into account prior conduct, going back over his whole life. Of course, this is said to be not for the purpose of punishing him. The proceedings are not criminal; if the person is found to be a sexual psychopath, he will not be found "guilty" or sent to a prison, he will be found in need of treatment and sent to a hospital. But if in fact the hospital has no treatment for him and he is subjected merely to custodial confinement just as he would be in prison (and some overcrowded hospitals may be worse than a modern, well-run prison), the distinction between "punishment" and "treatment" may in hard fact be wholly academic. What is worse, the duration of his confinement may be much longer. Instead of a thirty-day jail term for "window peeping," he may be confined for an indeterminate term—possibly for life. These possibilities have concerned many commentators, not only because of possible harshness and injustice, but also because of the erosion of constitutional rights. (See *Correctional Institutions and Psychiatry*)

Statutes that require only that the person be accused rather than convicted of a crime have been criticized as inconsistent with our Anglo-Saxon tradition that a person is not to be convicted except on the basis of overt acts. Prevention of crime is a laudable objective, but psychiatry is not an exact enough science to weigh all the factors that determine human conduct so as to be able to predict with any degree of assurance that a given person will commit a crime unless he is locked up. (See *Crime and Mental Disorders*)

Although the first sexual psychopath act, passed by Michigan in 1937, was held unconstitutional by the state supreme court, later acts have cured the defect found in that act and have been upheld by the courts, including the Michigan court. Because the proceeding is not criminal, courts have held that constitutional protections against self-incrimination, *ex post facto* laws, and double jeopardy do not apply. The right against self-incrimination, it is held, only protects against having to make statements that might result in conviction for crime. Similarly, the protection against double jeopardy does not apply, because that only protects one against being tried twice for the same crime. But when the confinement is in fact indistinguishable from imprisonment for crime, laymen may fail to be impressed by the difference in labels. (See *Law and Psychiatry*)

A report of the Group for the Advancement of Psychiatry says that unlawful sexual acts should be recognized as only one surface mani-

festation of a more profound psychological disturbance, and that such acts may be less significant than other symptoms to indicate serious disturbance of personality. Instead of naïvely classifying a certain group of offenders according to one symptom of abnormality, we should look beyond that one illegal act and assess the total personality, in order to enable the courts better to provide both community protection and individual treatment.

The difficulty of identifying the sexual psychopath and finding methods of treatment and cure, the lack of facilities where such treatment could even be attempted, and the need to balance the needs and the dangers of sexual psychopaths against the needs and dangers of other types of disordered persons who could not be taken care of if we load our facilities with incurable psychopaths, all require us to weigh carefully the probable functioning and effect of any legislation that might be considered.